AMENDMENT

It is hereby agreed by and between the Parties, **State of Vermont, Department of Vermont Health Access** (hereinafter called "State") and **DXC MS LLC** (the "Contractor") that Contract #35485A originally dated as of January 1, 2017, as amended to date, is hereby amended effective August 1, 2020 as follows:

I. Change in Contractor Organization and Information. DXC Technology Services, LLC is in the process of being consolidated into DXC MS LLC.

II. The entity name of the "Contractor" shall change from "DXC Technology Services LLC" to "DXC MS LLC" effective August 1, 2020.

III. For the State's record-keeping purposes, the Contract Number shall change from 35485 to 35485A.

IV. Contractor has submitted new W9 information to the State in connection with all billing.

V. Contractor hereby certifies that all insurance certificates previously provided to the State remain true and correct and describe insurance policies currently in effect and shall provide updated certificates with Contractor's new name information when any changes to insurance occur.

VI. **Maximum Amount.** The maximum amount payable under the Contract, wherever such reference appears in the Contract, shall be changed from $85,405,203.40 to $85,878,477.38 representing an increase of $473,273.98.

VII. **Attachment A, Scope of Services.** The Scope of Services is amended as set forth in Appendix I to this Amendment #5.

VIII. **Attachment B, Payment Provisions.** The Payment Provisions are amended as set forth in Appendix II to this Amendment #5.

IX. **Attachment E, Business Associate Agreement**. The Business Associated Agreement is amended as set forth in Appendix III to this Amendment #5.

Taxes Due to the State. Contractor further certifies under the pains and penalties of perjury that, as of the date this contract amendment is signed, the Contractor is in good standing with respect to, or in full compliance with a plan to pay, any and all taxes due the State of Vermont.

Child Support (Applicable to natural persons only; not applicable to corporations, partnerships or LLCs). Contractor is under no obligation to pay child support or is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date of this amendment.

Certification Regarding Suspension or Debarment. Contractor certifies under the pains and penalties of perjury that, as of the date this contract amendment is signed, neither Contractor nor Contractor's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for

debarment, declared ineligible or excluded from participation in federal programs, or programs supported in whole or in part by federal funds.

Contractor further certifies under pains and penalties of perjury that, as of the date that this contract amendment is signed, Contractor is not presently debarred, suspended, nor named on the State's debarment list at: http://bgs.vermont.gov/purchasing-contracting/debarment.

Sole Source Contractor Certification. This Contract results from a "sole source" procurement under State of Vermont Administrative Bulletin 3.5 process and Contractor hereby certifies that it is and will remain in compliance with the campaign contribution restrictions under 17 V.S.A. § 2950.

This document consists of 60 pages. Except as modified by this Amendment No. 5, all provisions of the Contract remain in full force and effect.

STATE OF VERMONT

DEPARTMENT OF VERMONT HEALTH ACCESS

E-SIGNED by Cory Gustafson on 2020-07-31 20:32:59 GMT July 31, 2020

CORY GUSTAFSON, COMMISSIONER DATE
NOB 1 South, 280 State Drive
Waterbury, VT 05671-1010
Phone: 802-241-0239
Email: Cory.Gustafson@vermont.gov

CONTRACTOR

DXC TECHNOLOGY SERVICES LLC

E-SIGNED by David Hadsell on 2020-07-31 19:16:53 GMT July 31, 2020

DAVID HADSELL, VP OF SALES, GLOBAL HEALTHCARE
Suite 101, 312 Hurricane Lane
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Appendix I

1. Section III (Additional One-time, Ongoing, and Future MMIS Modernization Projects), as previously amended, is hereby deleted in its entirety, and replaced as set forth below:

III. Additional One-time, Ongoing, and Future MMIS Modernization Projects

This section provides a summary of MMIS projects that are planned, in progress, and previously completed. The Change Management process will be followed for State authorization of the Contractor's project work outlined in this section. This work is not included in the base scope detailed within Section I and II of this Attachment A or included in the base price detailed within Attachment B. The State, at its sole discretion and upon availability of funding, may choose to initiate, continue, or stop work under any of these projects independently or otherwise. The parties will agree to the timing and schedule of each of these projects.

The Contractor will produce a monthly bill for the actual hours worked each month or for the deliverables approved by the State as described in the sections below. Any work performed in excess of the maximum hours set forth in the tables in the subsections below will require approval by the State prior to the Contractor performing the additional hours. The bill will include the hours used for each activity listed. The Contractor will be reimbursed at the customer service request (CSR) hourly rate described in Attachment B, unless the parties have agreed the project will be performed for a fixed price.

The Contractor must employ accessibility standards, processes, and commercially reasonable practices and apply these to all end-user applications. As independent external IT delivery methodologies and standards (such as those listed in Section II.D) are modified, commercially reasonable practices shall be enhanced and applied to any projects affected.

A. Medical Assistance Provider Incentive Repository (MAPIR) Core Development

The VT MAPIR Project is supported by an existing, approved Implementation Advance Planning Document (IAPD).

The State participates in the development of the Core MAPIR application in coordination with multiple states. The scope of Core MAPIR is for software enhancements due to CMS requirement changes, and for deployment of the Core MAPIR application updates and patches. Core MAPIR development payments will be invoiced on a quarterly basis at amounts indicated within Attachment B. Pricing may be adjusted if the number of members in the MAPIR Collaborative increases or decreases.

B. Vermont Specific MAPIR Integration/Customization

The scope of this effort is specific to the integration of the Core MAPIR enhancements into the Vermont MMIS environment; any associated custom effort required for Vermont specific needs and ongoing technical production activities.

The Installation and Customization of Core MAPIR releases consist of the following activities. The project budget for the duration of the contract, is based on the annual estimates below:

MAPIR Customization Activity	Annual Hour Maximum Years 1-3	Annual Hour Maximum Years 4-5	Contract Hour Maximum
Environmental Changes (DB2, Websphere/Stored procedures)	120	20	400
MAPIR Installation	120	80	520
State Configuration	80	100	440
Additional Customization	300	200	1300
Project Management	300	200	1300
Testing	120	100	560
Subtotal	**1,040**	**700**	**4,520**
Technical Support of VT production environment	500	300	2100
Annual Customization Hours	**1,540**	**1,000**	**6,620**

C. Payment and Delivery System (PADS) Reform

MMIS enhancements are required in support of the State's efforts to continue the expansion and the success of the reform efforts in alignment with the Vermont All Payer Model Agreement. The overarching goals of the work covered by payment reform enhancements include moving away from fee-for-service reimbursement models, increasing provider flexibility to deliver care, and ensuring high-quality data is available to evaluate program performance. MMIS enhancement areas for various programs to help meet these objectives have been identified in the table below. The total number of hours estimated for PADS work through December 31, 2021 is 9,196 hours.

MMIS System Work Description
Modify batch process and MMIS screens for third party liability claims, to support third party billing for Accountable Care Organization (ACO) claims that were not paid as fee-for-service
Assign Health Service Area, new Prior Authorization indicator values, and new attributing provider information when loading the ACO Provider Roster file, to support ACO financial reporting and reconciliation requirements. Display new information on MMIS screens.
Enhance MMIS and Business Objects data warehouse reporting capabilities, to support ACO financial reconciliation activities.
Allow claims service limit exceptions to prior authorization requirements for ACO members - codes, limits, associated flags, and reports
Reform Initiatives - MMIS enhancements

Support additional billing modifiers for reporting, billing, limits, flags, and payments for adult and child mental health claims (such as the T2025 case rates)
Capture federal poverty level (FPL) between the Vermont Department of Mental Health (DMH) and access for Community Rehabilitation and Treatment (CRT) populations
Applied Behavior Analysis (ABA) - MMIS analysis, design, development, and implementation for support of alternative payment models
Children's and Adult Mental Health - MMIS analysis, design, development, and implementation for support of detailed encounter data capture and payment models
Substance Use Disorder (SUD) waiver - modify MMIS claims and financial processing to support change to substance abuse program
Developmental Disability Services (DS) - MMIS analysis, design, development, and implementation for support of detailed encounter data capture and payment models
Pediatric Palliative Care - MMIS analysis, design, development, and implementation for support of alternative payment models
Children's Integrated Services (CIS)– modify MMIS claims and financial processing to support changes to payment models and encounter data capture
Support enhancements to analytics, data warehouse, data extracts and reporting to enable improved oversight and insights into reform initiatives - ACO, DMH, ABA, DS, CIS, other
Other MMIS enhancements as specified by the State in support of Reform Initiatives that are funded by Reform Initiative budgets.

D. TMSIS Reporting Enhancement Project

The State is seeking to improve data quality and provide additional TMSIS data elements. Effort is planned for enhancements to derive and obtain additional data to include in TMSIS reporting.

The defined Project work identified in the tables below is ongoing in response to continued data quality work with CMS and its TMSIS contractors. A budget is established for monthly quality analysis, design, and implementation of further improvements to TMSIS data quality. This Quality Analysis and Improvements budget will enable ongoing assessment with CMS and its vendors for future enhancements beyond those identified to-date.

Summary

Data Quality Analysis and Improvements	**Hours**
2018 Data Monthly Quality Analysis and Improvements	720
2019 Monthly Quality Analysis and Improvements	720
2020 Monthly Quality Analysis and Improvements	5,704
2021 Monthly Quality Analysis and Improvements	5,704
GAP Compliance - complete	645

Addendum B Table 3 - (through December 2019, absorbed into data quality for 2020 and future)	2,070
Common Solution Integration – (through December 2019, absorbed into data quality for 2020 and future)	940
Total Project Hours	**16,503**

E. Technology Updates

Due to the age of current technologies and known business drivers, the following areas of MMIS technology have been identified as needing to be addressed under this Contract. These projects will require additional definition and funding through a contract amendment, change order, or other work authorization mechanism.

i. Enhance report generation and analytic capabilities:

The Contractor will update the commercial software technology and configuration of the tools used for ad-hoc queries and reporting of MMIS Claims and Provider data, as performed by the State and the Contractor's employees. Change Request hours from the annual hours budget included in the fixed price amount may be authorized by the State for performance of this work.

ii. Migrate MMIS report and document archival to a standardized Content Management (CM) platform: The current IBM OnDemand (third party) software and server platform used for Content Management of paper claims images, batch reports, and other documents, is at end-of-life for Contractor support and does not meet State needs for access to MMIS information. The Contractor shall retire the current software and systems and integrate MMIS with a State approved CM as a Service solution.

The project scope will include effort associated with the migration of existing MMIS Contractor OnDemand system to a State provided Content Management Platform. The Contractor will provide the following within the scope of the project:

- Develop and test an interface between the MMIS AIM system and the CM service to send MMIS files to the CM service daily
- Support the evaluation of existing MMIS batch reports and other file types with the State to confirm which archived content will be migrated to the new CM service.
- Migrate existing archived content from the existing solution as agreed upon with the State via the approved CM interface.

The Contractor has budgeted for 1,000 hours of effort for this activity. This work will be performed as directed and agreed to by the State.

F. Enhanced EDI Services Migration Project

i. Project Summary

The State anticipates submitting an IAPD to CMS for support of a project to migrate to an enhanced Electronic Data Interchange (EDI) service.

In support of ongoing processing of claims and other Accredited Standards Committee (ASC) X12 EDI standard health insurance transactions, and in compliance with ACA 1104 required CAQH CORE Operating Rules, the Contractor shall prepare for updated EDI transaction standards and requirements. A technical need exists to migrate State transaction processing from the current SAP Sybase (third-party) software platform, and associated Contractor "EDI Shared Translator" services. The Sybase ECRTP translator software is no longer being offered as a commercial product by the vendor SAP. This lack of support poses risks to current operations and the ability to meet future federal requirements. The Contractor shall migrate the State's MMIS to interface with a new EDI Software as a Service (SaaS) solution as an initial project phase. A second phase will follow to implement new transaction standards (once finalized).

The Enhanced EDI SaaS solution is based on IBM Commercial Off-The-Shelf (COTS) software and is currently utilized by multiple other state Medicaid programs. Compliance checking will comply with the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) WEDI/SNIP types at currently supported State SNIP types for EDI transactions identified below.

ii. Transaction Scope

EDI compliance and translation support is currently provided for the following inbound batch transactions for trading partner file exchange with the Vermont MMIS (AIM) System and will continue to be provided with the enhanced EDI solution:

- 270 Health Care Eligibility Benefit Inquiry
- 276 Health Care Claim Status Request
- 837D Health Care Claim - Dental
- 837I Health Care Claim - Institutional
- 837P Health Care Claim – Professional
- Payer Initiated Eligibility/Benefit (PIE) Transaction (X279A1)

EDI compliance and translation support is currently provided for the following outbound batch transactions for trading partner file exchange with the Vermont MMIS (AIM) System and will continue to be provided with the enhanced EDI solution:

- 271 Health Care Eligibility Benefit Response
- 277 Health Care Claim Status Response
- U277 Unsolicited Claims Status Response
- 820 Health Insurance Exchange Related Payments
- 835 Health Care Claim Payment Advice
- 999 Implementation Acknowledgement

EDI compliance and translation support is currently provided for the following real-time transactions for trading partner file exchange with the Vermont MMIS (AIM) System and will continue to be provided with the enhanced EDI solution:

- 270 Health Care Eligibility Benefit Inquiry
- 271 Health Care Eligibility Benefit Response

- 276 Health Care Claim Status Request
- 277 Health Care Claim Status Response
- 999 Implementation Acknowledgement

The following non-standard file formats will be provided in conjunction with the enhanced EDI SaaS solution:

- Proprietary format of remittance advice files, equivalent to those currently provided in addition to the 835 RA files.
- Proprietary HTML file format for batch acknowledgements, to contain same information as in the 999 acknowledgements in a browser (i.e. human) readable format.

System-to-System File Exchange is currently provided in compliance with CAQH 'Safe Harbor' Phase I, II, and III CORE operating rules. The enhanced EDI Service will remain compliant with current and future required CAQH CORE operating rules and Phases, as federally required. The enhanced EDI Service will provide equivalent web-based, compliant file exchange services on a new platform.

iii. Implementation Scope

The following areas of technical work will be performed by the Contractor, to migrate from the current EDI shared service to the enhanced EDI SaaS service. A combination of leveraged EDI services team and account-based technical and operations staff, will perform this work:

- Installation and Configuration of Model Office, User Acceptance, and Production environments for enhanced EDI services, including all required IT infrastructure and software.

- Analysis and testing of VT electronic claims transaction files to identify any compliance gaps between the current and new EDI compliance rules.

- Design, Construction, and Testing of interfaces between the enhanced EDI solution and Vermont MMIS AIM systems, for batch and real-time EDI transaction processing.

- Modification of existing MMIS AIM system programs, to accept and produce standard XML file formats for exchange of transaction files and trading partner authentication data with the enhanced EDI service. This work will allow utilization of reusable, common EDI translation maps, thereby reducing current and future customization efforts. Local customization required will be done outside of the common maps.

- Systems integration testing will occur in the MMIS Model Office environment, to execute planned functional testing for in-scope transactions and interfaces.

Production EDI files will be used for high-volume testing, to maximize test coverage for the myriad of possible transaction data combinations.

- A two-month window for trading partner testing will occur in the User Acceptance Test EDI and MMIS test environment. Trading partner testing will be enabled via MMIS systems such as the Provider Portal website and supported by the Contractor EDI coordinator and Contractor technical staff. Trading partners will be encouraged through Provider communication and outreach, to submit test transactions to ensure readiness.

iv. Timeline

The detailed work plan will define a schedule for implementation activities, to be followed by a trading partner testing window. Upon the go-live implementation date, State trading partners will begin use of the production version of enhanced EDI services. The start of the project will begin on a date agreed to by the Contractor and the State, and as supported by an approved CMS Implementation APD plan.

v. Deliverables

The following deliverables shall be produced by the Contractor for the EDI migration project:

- A compliance analysis and design document will be produced to identify impact(s) to the EDI Companion Guides where a change in technology may introduce new compliance rules.

- A detailed Project Work Plan (i.e. Project Schedule), in Microsoft Project format, by day 60 of the implementation project.

- EDI Interface Design documents, for integration between the enhanced EDI Service and existing MMIS systems, by day 60 of the implementation project or as defined in the project schedule.

- Transaction crosswalk design documents, for identifying X12 field level requirements, by day 90 of the implementation project or as defined in the project schedule.

- A Systems Test Plan and related test artifacts, to document the systems integration, interface, and trading partner testing scope and detailed test cases. A final version of this deliverable will include pass/fail test results, to be provided to the State for review no later than end of month six (6) of the implementation timeline or as defined in the project schedule.

- Updated EDI-related business documentation where necessary, for Provider-facing information and instructions on use of EDI services, to be provided to the State for review no later than end of month six (6) of the implementation timeline or as defined in the project schedule.

- Provider communications activities and deliverables will be jointly agreed upon with the State and identified in the detailed Project Work Plan deliverable.

vi. Implementation Budget

The project budget for implementation of the enhanced EDI service is planned as fixed price, one-time costs to be invoiced based on State acceptance of the following schedule of deliverables.

Enhanced EDI Service Implementation Deliverable	Fixed Price Charge
Claim Compliance Analysis testing and design	$93,750
Acceptance of Project Work Plan, EDI Interface Design, and transaction crosswalk deliverables; EDI Service Model Office and UAT test environments are installed	$100,000
Implementation Project Complete, Trading Partners migrated to enhanced EDI Service, all Project deliverables accepted	$250,000
Total One-Time Costs	**$443,750**

G. Provider Services Enhancement Project: Complete

The Provider Management Module (PMM) was a project under the MMIS Program and is part of the overall MMIS Road Map as presented to CMS. The project milestones were completed upon CMS certification of the PMM modules in February 2020. The PMM project was a high priority legislative initiative aimed to reduce the timeframe to enroll Medicaid Providers. The bill that has been introduced is S.282, https://legislature.vermont.gov/bill/status/2018/S.282. The bill requires the State to complete screening and enrollment for an applicant to be a participating Provider in the Medicaid program within 60 calendar days after receiving the application, direct the State to identify and report on the main concerns of the participating Providers, and to make recommendations for any necessary changes to the Medicaid fraud and abuse statutes. Further specifications are defined in Exhibit 3 to Attachment A.

The Contractor delivered the enhanced Provider Services SaaS, which is being utilized by Providers, the State, and the Contractor in continued performance of the Contractor's Provider Services fiscal agent (FA) responsibilities as described in Exhibit 3, Provider Services Enhancement Project Scope of Work.

The project budget for implementation of the Provider Services SaaS was planned as fixed price costs to be invoiced based on State acceptance of the following schedule of deliverables:

DDI Phase	Deliverables Included	Payment
Planning and Installation	Install Test Environments Project Management Plan Quality Management Plan Data Conversion Specifications Testing Artifacts – initial version Training Plan	$450,000
Integration Testing and User Acceptance Testing	Business Configuration Specifications Documentation Testing Artifacts – Final Versions Requirements Traceability Matrix (RTM) Training Rosters	$722,826
Implementation	Operational Checklist and Results Solution Documentation for Software Modules Interface and Deployment Specifications	$1,150,000
Certification	Certification Management Plan CMS Certification Checklists deliverables Certification Acceptance	$700,000
Total		**$3,022,826**

H. Electronic Visit Verification Project

The purpose of the project is to ensure the State is compliant with Section 12006 of the 21st Century CURES Act, which was passed by the U.S Congress in December 2016 and mandates States to implement Electronic Visit Verification (EVV) solutions for defined personal care services. Non-compliance of the requirements can lead to a reduction in the Federal Medical Assistance Percentage (FMAP) for the associated personal care services.

The Contractor will deliver the EVV solution as SaaS which will be utilized by personal care providers, the State, and its agents. The following software modules will be made available via the Internet:

- Santrax Electronic Visit Verification
- Santrax Provider EVV Portal
- Santrax Consumer Directed Care Fiscal Portal
- Santrax Jurisdictional View Portal

The Contractor shall provide an electronic visit verification system that meets the following requirements:

- The Electronic Visit Verification system will be available for personal care services effective June 1, 2020 or as agreed to by the State and CMS.
- The Electronic Visit Verification system will be available for receiving data from home health service systems effective January 1, 2020.
- The Electronic Visit Verification system must be compliant with Section 12006 of the 21st Century Cures Act.

Data exchange between the EVV solution and existing State and Contractor systems will occur as specified in Attachment A, Exhibit 4 Electronic Visit Verification Project Statement of Work to enable the EVV solution and to provide EVV data to MMIS systems to enhance operational program oversight of personal care services.

Limited training for use of EVV software is included in the implementation scope. Ongoing support of EVV modules includes regular software updates and user help desk support.

The project budget for the implementation phase of the EVV solution is planned as fixed price costs to be invoiced based on State acceptance of the implementation deliverables. Ongoing service charges shall be billed at the rates and frequencies specified in Table A below. EVV Certification and customization requests shall be billed in accordance with State approved Specification Orders not to exceed the budgeted amounts listed below.

Table A: EVV Implementation / Operations Budget

Phase	Deliverables Included	Payment	Billing Frequency	Total Budget per Line Item
Implementation	Implementation deliverables to be paid as specified in Attachment A, Exhibit 4 Electronic Visit Verification Solution Statement of Work	$784,400	Per Exhibit 4	$784,400
EVV Support	Ongoing support, as specified in Attachment B, Section 5 A. MMIS Operations of this document.	$7,273.33	Monthly, beginning 3/1/2020	$174,560
EVV Operations	Minimum transactional service charges, as specified in Attachment B, Section 5 A. MMIS Operations of this document.	$5,437.46	Monthly, to begin upon use of portals for consumer directed care training	$130,499.10
Operations – Visits per member per month (PMPM) over minimum transactions, Billed as Utilized	Excess EVV Transactions Estimates as specified in Section B i.v. Volume and Accounting section of this document. EVV Recurring Visit Fee represented here is estimated only for budget purposes.	$0.225 per transaction over the minimum transaction ceiling	Monthly	$130,498.66
Operations – Aggregator PMPM Billed As Utilized	Aggregator fee PMPM as specified in Section B i.v. Volume and Accounting section of this document. Fee represented here is estimated only for budget purposes.	$1.375 per Member per month	Monthly	$82,474.22

Certification Services – Billed as Utilized	Outcome-based certification scope will be authorized against this budget via Specification Orders.	$355,306	Per Completed and State Approved Specification Order(s)	$355,306
Customization Requests – Billed As Utilized	Additional customization work for EVV modules or MMIS to support State business requirements, will be authorized against this budget via Specification Orders.	$100,000	Per Completed and State Approved Specification Order(s)	$100,000
Training Revised Scope	For CDS webinars as identified in Attachment A Exhibit 4	$7,872	Per Exhibit 4	$7,872
Additional PM support	For Contractor Project Manager for January 2020 through December 2020 to support extended CDS implementation window	$28,533.33	Monthly	$342,399.96

I. Payer-Initiated Eligibility Information Exchange (PIE) Transaction

The scope of this project is for the Vermont MMIS system to support the CMS standard for transmission of Payer-Initiated Eligibility Information Exchange (PIE) Transaction data to be received from carriers such as Blue Cross Blue Shield of Vermont, Cigna, and MVP. Existing data matching reports will be leveraged with these new sources of member eligibility data for Coordination of Benefits purposes. Additional enhancements will be made in support of improved member matching and automation of COB information into the State's ACCESS system. MMIS technical work activities will include analysis, design, construction, testing, and project management. Testing effort will include integration testing between MMIS and ACCESS systems, as well as support of testing with additional carriers.

PIE Data Match Activity	Hour Estimates
Analysis and Design	100
Construction and Testing	325
Project Management	75
Subtotal Hours Estimate	**500 hours**

J. New Medicare Card Project: Complete

Medicare Card Project work concluded in May 2018. There is no further work planned for this project and the Contractor shall make no further claim for payment for this project. The State received an approved IAPD from CMS for support of the Medicare Card project, including work to be done in the MMIS system.

Congress passed Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015 (PL 114-10) on April 16, 2015. Section 501 of MACRA requires

CMS to remove the Social Security Numbers (SSNs) from Medicare cards and replace with a Medicare Beneficiary Identifier (MBI).

Policies and systems were examined, the appropriate changes identified, and modifications tested prior to CMS distributing new Medicare cards. MMIS required modification to integrate with other State systems in order to accommodate the load, storage, display, and reporting of a new MBI identifier for members. The project timeline for MMIS project changes aligned with the schedule proposed in the IAPD. Construction and functional systems testing of MMIS occurred in September 2017 through March 2018, with integration testing and implementation activities for MMIS changes occurring from January through May of 2018.

Summary

Medicaid Card Project – VT MMIS System Changes	
REQUIREMENTS DEFINITION AND ANALYSIS **CONSTRUCTION AND TESTING BATCH**	
Produces the rekr650v report - Medicare Suspect Recipient. Ran Monthly and contains the HICN.	
Processes the daily medi.dat file that contains the HICN.	
Processes the daily eligibility file containing the HICN.	
Creates the PDP 820 Premium file that contains the HICN.	
Creates the PDP Premium Remittance Report that contains the HICN. Mailed to PDPs.	
Creates the Medicaid Remittance Advice. Claims that are denied for Medicare on the RA have the members Medicare ID printed on the RA.	
Creates the GCR recipient extract that contains the HICN.	
Uses the presence of a HICN to set a recipient Medicare indicator to a 1 in the t_recipient_info table in EVAH.	
TMSIS file creation, includes the HICN.	
TMSIS file creation, includes the HICN from crossover claims that have it.	
TMSIS Inpatient file creation, includes the HICN from crossover claims that have it.	
TMSIS Nursing Home file creation, includes the HICN from crossover claims that have it.	
TMSIS Other file creation, includes the HICN from crossover claims that have it.	
TMSIS Pharmacy file creation, includes the HICN from crossover claims that have it.	
Creates the COBA file sent to Medicare monthly that contains the members HICN.	
Creates the COBB file sent to Medicare monthly that contains the members HICN.	
Screens	
Recipient LIS Information - Displays the HIC #	
Recipient Header - Displays and allows query by the HIC #	
Recipient Base - Displays and allows query by the HIC #	
Other Insurance - Displays the HIC #	
Tables	
t_re_medcr_id table	
Total Hours	**275.25**
Total Cost	**$33,555.28**

K. Presumptive Eligibility (PE) Project: Complete

Presumptive Eligibility Project work concluded in March 2018. There is no further work planned for this project and the Contractor shall make no further claim for payment for this project.

Vermont hospitals may determine presumptive eligibility as allowed under 42 CFR 435.1110. The State provides Medicaid coverage for individuals under this provision, consistent with Vermont DCF Health Benefits Eligibility and Enrollment rule 66.04. Enhancements to the MMIS system were needed to align with ACCESS eligibility system enhancements, where MMIS receives, for purposes of claims processing, an eligibility record with one of multiple new aid categories to identify members who have received presumptive eligibility. MMIS eligibility inquiry features and financial reporting were updated by the Contractor, to provide presumptive eligibility information.

Summary	Developer	Analyst/PM
REQUIREMENTS DEFINITION AND ANALYSIS	40	20
CONSTRUCTION AND TESTING		
UPDATE MMIS COPAY LOGIC TO EXCLUDE PRESUMPTIVE ELIGIBILITY AID CATEGORY	3	3
ADD 2 FINANCIAL REPORTING NEW SUB BUCKETS UNDER GLOBAL COMMITMENTS FOR PE	25	15
ADD NEW AID CATERGORIES FOR PRESUMPTIVE ELIGIBILITY PROGRAM	50	20
MODIFY THE DAILY ELIGIBILITY FEED TO ACCEPT FOUR NEW AID CATEGORY CODES	10	5
MODIFY ELIGIBILITY VERFICATION SYSTEMS TO ACCOMMODATE NEW PRESUMPTIVE ELIGIBILITY PROGRAM	25	10
IMPLEMENTATION SUPPORT	40	
Subtotal Change Effort Hours	193	73
Total Hours		**266**

L. Medicare Grant Project: Complete

Medicare Grant Project work concluded in July 2017. There is no further work planned for this project and the Contractor shall make no further claim for payment for this project.

MMIS processes the Medicare Blueprint and Community Health Team (CHT) payments on behalf of the State through a Medicare Grant effective 1/1/2017. Funding originates from CMS for Medicare beneficiaries and the State pays the Providers on behalf of Medicare.

The following enhancements to MMIS were completed via State only funding. A one-time amount of $13,200 was invoiced upon completion and promotion to MMIS production of these changes:

- The MMIS uses Medicare Blueprint rates each month to generate lump sum Medicare

Blueprint payments. The Medicare CHT payments are processed quarterly.

- A special program payment type and financial reason codes will identify the payments.
- The MMIS screen Provider Special Program (PRSP) is used to enter and maintain the providers who are eligible for the Medicare Blueprint and CHT payments and the Reference Special Program Rates (RFSP) screen is used to enter and maintain the rates.
- Two new special program payment types (BM – Blueprint Medicare, CM – CHT Medicare) and two financial reason codes were assigned to the payments. (Financial Reason Code 361- Medicare Blueprint Payment and 362 – Medicare CHT Payment)
- The FBR (Financial Balancing Report) was updated to report the Medicare Blueprint and CHT payments in the "Federal" bucket, sub-bucket of None.

M. Provider 6028 Project: Complete

The VT Provider 6028 Project concluded in April 2017 and was supported by an Implementation Advance Planning Document (IAPD) with CMS. There is no further work planned for this project and the Contractor shall make no further claim for payment for this project.

ACA Rule 6028 introduced guidelines to State Medicaid Agencies regarding Provider Credentialing and Certification for Providers who are participating and being reimbursed by the Medicaid program. This project identified and performed several enhancements to the MMIS system and identified process changes to meet these compliance guidelines.

The Provider project scope included detailed process analysis, systems design, construction, testing, and project management of required enhancements in the following areas:

Item #	Item	Billing	Provider 6028 Project Description
1	**MMIS LexisNexis File Exchange**	$0.00	MMIS System and Integration Testing Phase of the LexisNexis File Exchange process and LexisNexis Base Package Files. MMIS Construction, System and Integration Testing of the Advanced Package Files. Ref. 42 CFR § 455.412(a)(b), § 455.436, § 455.452
2	**Collection of Provider Enrollment Fees**	$0.00	Create a Manual Process for Collecting of Provider Enrollment Fees and MMIS modification to create a new screen to capture if they have paid the fee to Medicare, to another Medicaid program, or to Vermont Medicaid. Create new financial transactions to capture the enrollment fee under the refund functionality in the MMIS. Assumption: Estimate assumes a manual process for updating the new Enrollment Fee information in the MMIS. Ref. 42 CFR § 455.46

Item #	Item	Billing	Provider 6028 Project Description
3	**LexisNexis – MMIS Automated Processes**	$2,360.94	The **Provider Updates 2014** Project introduced the LexisNexis Advanced Package of data files to the MMIS. This item is to build upon the data available in these files. The Contractor will work with the State to review data in the post-production data feeds and recommend processes to automate data updates in the MMIS. Possible items that could be built under this item include: Updating Provider License Expiration Dates, Updating Provider DEA, and DEAX Expiration Dates, Adding/Updating/Deleting Provider Service Address Information, Modification to Provider Risk Assessment Level, etc. Ref. 42 CFR § 455.412(a)(b), § 455.436
4	**Automated Welcome Letters and Revalidation Acknowledgement Letters**	$434.20	Welcome Letters are manually generated when new Providers are enrolled in the Vermont Medicaid Program. There are four different types of letters generated. A new requirement to the MMIS is to generate an acknowledgement when a provider revalidates their credentials and renews their enrollment in the Vermont Medicaid Program. This item is to automate the generation of both the Welcome Letters and the Revalidation Acknowledgement Letters.
5	**Fingerprint Background Screenings for Providers and Disclosing Entities**	$0.00	This item includes time to incorporate Fingerprinting into the MMIS Provider Credentialing Process. There is not currently enough information at this time to provide a detail analysis of impacts to the MMIS. Estimate includes efforts to create a Screen to capture those providers who have been Fingerprinted, when that occurred, and simple Provider Reports to list the new Fingerprinting data. Assumption: Estimate assumes a manual process for updating the Fingerprinting data in the MMIS. (DAIL's Fingerprinting Efforts is separate from the MMIS Fingerprinting efforts/process.) Estimate does not include any cost associated with Third Party Vendors which may be necessary to perform Fingerprinting and the background checks. Ref. 42 CFR § 455.434 (a) and (b)(1)(2) and § 455.450
Total Project Cost			**$2,795.14**

2. Exhibit 2 Service Level Requirements beginning on page 54 of 106 of the base agreement, and as previously amended, is deleted and replaced by the following Exhibit 2, Service Level Agreement:

Exhibit 2
Service Level Agreement

Category	SLA #	SLA Title	Target	Service Level Credit
CLAIMS	SLA #1	Notification of Incorrect Payments	100% within 5 business days	Cumulative Credit
	SLA #2	Adjudicate Claims Within 15 Days	80.0% within 15 calendar days	Cumulative Credit
	SLA #3	Adjudicate Claims Within 30 Days	90.0% within 30 calendar days	Cumulative Credit
	SLA #4	Adjudicate Claims Within 90 Days	99.0% within 90 calendar days	Cumulative Credit
	SLA #5	Adjudicate Claims Within 150 Days	100.0% within 150 calendar days	$1,000/month
	SLA #6	Claim Error Rate	Less than 3.0% error rate	$5,000/month
	SLA #7	Timely Reference Updates	100% within 5 business days	Cumulative Credit
	SLA #8	Reference Error Rate	Less than 5.0% error rate	Cumulative Credit
FINANCIAL	SLA #9	Mail Accident/Injury Questionnaires	100% within 30 calendar days	Cumulative Credit
	SLA #10	TPL Referral & EOB Verification	100% within 30/60 calendar days	Cumulative Credit
	SLA #11	Disposition Cash	100% within 45 calendar days	Cumulative Credit
	SLA #12	Deposit Cash	100% within 24 calendar days	Cumulative Credit
	SLA #13	Aged AR Letters	100% within 30/60/90 calendar days	Cumulative Credit
	SLA #14	Bank Reconciliation	100% within 30 calendar days	Cumulative Credit
	SLA #15	Financial Draw	100% within 2 business days	$1,000/month
	SLA #16	Financial Balancing Report (FBR)	100% within 2 business days	$1,000/month
	SLA #17	Timely Financial Requests	100% within 5 business days	Cumulative Credit

	SLA #18	Financial Request Error Rate	Less than 5.0% error rate	Cumulative Credit
PROVIDER	SLA #19	Acknowledge Provider Inquiries	100% within 2 business days	Cumulative Credit
	SLA #20	Provider Call Center	100% availability per calendar month; M-F 8AM-5PM	Cumulative Credit
	SLA #21	Call Abandon Rate	Less than 9.0%	$5,000/month
	SLA #22	Enrollment	100% within 30 business days	$1,000/month
SYSTEM	SLA #23	Load Electronic Claims	100% within 24 hours	Cumulative Credit
	SLA #24	Drug Claim Transactions	100% within 48 hours	Cumulative Credit
	SLA #25	System Availability - Internal Facing	99.50% availability per calendar month M-F 6AM-6PM	Cumulative Credit
	SLA #26	System Availability - External Facing	99.50% availability per calendar month; 24/7	$1,000/month
	SLA #27	User Accounts	90.0% within 5 business days	Cumulative Credit
GENERAL	SLA #28	Key Staff	100% within 60 calendar days	$200/day out of compliance
	SLA #29	System Changes	100% completed as expected	$500/occurrence. 20% recoupment of total CSR-related hours invoiced to that deliverable. The correction(s) needed will be performed without additional cost to the SOV.
	SLA #30	Incurred Fees & Penalties	100% free of fees & penalties	$500/occurrence plus damages
	SLA #31	1099 Files	100% by January 31st	The amount imposed by the IRS for each and every individual incident.
	SLA #32	Client Communications	95.0% by the next business day	Cumulative Credit
	SLA #33	Service Level Reporting	100% within specified timelines	$1,000/month

SLA Descriptions

Any incidents where Service Levels are impacted will be reported to SOV using the Contractor's documented Incident Management process in addition to monthly SLA reporting.

SLA #1	**Notification of Incorrect Payments**
DESCRIPTION	Notify the state within 5 business days of the discovery of overpayments, duplicates or incorrect payments. Provide the State with a corrective action plan for detailed report on the payment errors with recommendation (adjustment, recoup, other) within 5 business days of notice of incorrect payment.
TARGET	100% within 5 business days
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #2	**Adjudicate Claims Within 15 Days**
DESCRIPTION	Adjudicate 80.0% of claims (excluding drug claims) within 15 calendar days of receipt.
TARGET	80.0% within 15 calendar days of receipt
EXCEPTIONS	Excludes drug claims (claim type D); Not limited to clean claims.
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #3	**Adjudicate Claims Within 30 Days**
DESCRIPTION	Adjudicate 90.0% of claims (excluding drug claims) within 30 calendar days of receipt
TARGET	90.0% within 30 calendar days of receipt
EXCEPTIONS	Excludes drug claims (claim type D); Not limited to clean claims
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #4	**Adjudicate Claims Within 90 Days**
DESCRIPTION	Adjudicate 99.0% of claims (excluding drug claims) within 90 calendar days of receipt.
TARGET	99.0% within 90 calendar days of receipt
EXCEPTIONS	Excludes drug claims (claim type D); Not limited to clean claims.
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #5	**Adjudicate Claims Within 150 Days**
DESCRIPTION	Adjudicate 100.0% of claims (excluding drug claims) within 150 calendar days of receipt.
TARGET	100.0% within 150 calendar days of receipt

EXCEPTIONS	Excludes drug claims (claim type D); Not limited to clean claims. SoV may grant an exception for a specific month, if metric is not met due to pending state actions for specific claims.
RESULT OF FAILURE TO MEET TARGET	$1,000 per month
SLA #6	**Claim Error Rate**
DESCRIPTION	Maintain an error rate of less than 3.0% on all claims manually processed by a resolution clerk. 3 claims per resolution clerk per day will be verified by the Quality Assurance analyst. The formula for calculating this SLA: [total # of errors discovered]/[total # of claims reviewed]
TARGET	Less than 3.0% average for the resolution team per month
EXCEPTIONS	If any one resolution clerk has an individual error rate of 3.0% or higher, DXC will provide additional support/training to the clerk. Details of the errors will be available to the State upon request. If the SOV agrees for a specific month, DXC may substitute the review of specific edits/audits in lieu of the per clerk review.
RESULT OF FAILURE TO MEET TARGET	$5,000 per month
SLA #7	**Timely Reference Updates**
DESCRIPTION	Complete reference file updates within 5 business days of receipt of complete authorized request or within 5 business days of effective date of change.
TARGET	100% within 5 business days
EXCEPTIONS	If the effective date of the change is more than 5 business days in the future, the update will be completed within 5 business days of the effective change.
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #8	**Reference Error Rate**
DESCRIPTION	Maintain an error rate of less than 5.0% on reference file updates processed. Sample size must be at least 30% of the total updates completed during the calendar month.
TARGET	Error rate of less than 5.0% per month
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #9	**Mail Accident/Injury Questionnaires**
DESCRIPTION	Produce and mail accident/injury questionnaires to members within 30 calendar days from cycle date.

TARGET	100% within 30 calendar days
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #10	**TPL Referral & EOB Verification**
DESCRIPTION	Perform follow up and verification of changes on all TPL referrals within 30 calendar days of receipt and all TPL EOBs within 60 calendar days of receipt.
TARGET	100% within 30/60 calendar days of receipt
EXCEPTIONS	Exclude the number of calendar days that the referral or EOB is with the SOV from the total number of calendar days.
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #11	**Disposition Cash**
DESCRIPTION	Disposition all cash receipts within 45 calendar days of deposit.
TARGET	100% within 45 calendar days of deposit
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #12	**Deposit Cash**
DESCRIPTION	Deposit within 24 hours of receipt.
TARGET	100% within 24 hours of receipt
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #13	**Aged Accounts Receivable (AR) Letters**
DESCRIPTION	Send letters to providers when their AR has aged to 30, 60, and 90 calendar days.
TARGET	100% within 30/60/90 calendar days
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #14	**Bank Reconciliation**
DESCRIPTION	Perform bank reconciliation within 30 calendar days of month end.
TARGET	100% within 30 calendar days
EXCEPTIONS	None

RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #15	**Financial Draw**
DESCRIPTION	Produce financial draw, reports and letters within 2 business days after completion of the financial payment cycle.
TARGET	100% within 2 business days
EXCEPTIONS	Manual adjustments requested by State that weren't known in advance of the reporting period.
RESULT OF FAILURE TO MEET TARGET	$1,000 per month
SLA #16	**Financial Balancing Report (FBR)**
DESCRIPTION	Produce weekly FBR within 2 business days after completion of financial cycle. Summary and detailed reports will be stored on DXC's SharePoint site each month; reported by the 10th of the following month.
TARGET	100% within 2 business days
EXCEPTIONS	Manual adjustments requested by State that weren't known in advance of the reporting period.
RESULT OF FAILURE TO MEET TARGET	$1,000 per month
SLA #17	**Timely Financial Requests**
DESCRIPTION	Complete financial requests within 5 business days of receipt of complete authorized request or within 1 business day of effective date of change.
TARGET	100% within 5 business days
EXCEPTIONS	If the effective date of the change is more than 5 business days in the future, the update will be completed within 1 business days of the effective change.
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #18	**Financial Request Error Rate**
DESCRIPTION	Maintain an error rate of less than 5.0% on all financial requests.
TARGET	Error rate of less than 5.0% per month
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #19	**Acknowledge Provider Inquiries**
DESCRIPTION	Acknowledge all provider voice messages, emails, and written communication by either phone or email within 2 business days of

	receipt to let the provider know the inquiry has been received and will be addressed.
TARGET	100% within 2 business days of receipt
EXCEPTIONS	Acknowledgment does not constitute a resolution of the issue or question.
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #20	**Provider Call Center**
DESCRIPTION	Maintain provider call center every Monday - Friday from 8:00 AM EST - 5:00 PM EST This is measured by availability of the phone system as well as the availability of agents to answer phones.
TARGET	100% availability per calendar month Monday - Friday from 8:00 AM EST - 5:00 PM EST
EXCEPTIONS	The call center may close for up to 1-hour at a time for a total of 3 hours per month for team meeting and trainings.
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #21	**Call Abandon Rate**
DESCRIPTION	Maintain call abandon rate of less than 9.0%.
TARGET	Less than 9.0%
EXCEPTIONS	Special considerations will be given at times when call volume is especially high due to new initiatives that result in provider inquiries. This exception will only be valid if there is approval by the DVHA Provider & Member Relations Director.
RESULT OF FAILURE TO MEET TARGET	$5,000 per month
SLA #22	**Enrollment**
DESCRIPTION	Compete all new enrollments, re-enrollments, and revalidation enrollment requests submitted either electronically via Provider Portal or via paper by the provider within 30 business days of receipt.
TARGET	100% within 30 business days
EXCEPTIONS	The number of days that the enrollment is with the SOV for action shall not be counted against this SLA. Examples include but are not limited to: site visits and state reviews.
RESULT OF FAILURE TO MEET TARGET	$1,000 per month

SLA #23	Load Electronic Claims
DESCRIPTION	Load all electronic claims within 24 hours of receipt.
TARGET	100% within 24 hours
EXCEPTIONS	Crossovers may exceed the allowed number of ICNs available per day due to mass adjustments being processed by Medicare. In those cases, any crossover claims that cannot be loaded due to a lack of ICNs will not be counted against this SLA.
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #24	**Drug Claim Transactions**
DESCRIPTION	Process drug transactions within 48 hours of receipt.
TARGET	100% within 48 hours
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #25	**System Availability - Internal Facing**
DESCRIPTION	Maintain access to all internal facing applications every Monday - Friday 6:00 AM EST - 6:00 PM EST with 99.5% availability per month. Internal (DXC and State of Vermont) facing applications include: MMIS/AIM, OnDemand, BusinessObjects, SharePoint. The formula for calculating this SLA: [total minutes of planned uptime for the month - total minutes of unplanned downtime for all supported systems within scope of this SLA] / [total minutes of planned uptime for the month] Minutes of downtime is tracked based on incident reports generated for each instance of downtime. Total minutes of planned uptime is based on number of apps and hours of the availability specified by the SLA.
TARGET	99.5% availability per calendar month Monday - Friday 6:00 AM EST - 6:00 PM EST
EXCEPTIONS	If downtime needs to be scheduled, at least one business day notice will be provided to stakeholders.
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #26	**System Availability - External Facing**

DESCRIPTION	Maintain access to all external facing applications with 99.5% availability per month. External (public/provider) facing applications include: VTMedicaid.com website, provider portal, electronic data interchange (EDI), PES, Provider Management Module (PMM) portal, AVRS eligibility. The formula for calculating this SLA: [total minutes of planned uptime for the month - total minutes of unplanned downtime for all supported systems within scope of this SLA] / [total minutes of planned uptime for the month] Minutes of downtime is tracked based on incident reports generated for each instance of downtime. Total minutes of planned uptime is based on number of apps and hours of the availability specified by the SLA.
TARGET	99.5% availability per calendar month; 24 hours/day, 7 days/week.
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	$1,000 per month
SLA #27	**User Accounts**
DESCRIPTION	Provide user account (MMIS/AIM, BusinessObjects, SharePoint, OnDemand, etc.) access to State of Vermont personnel within 5 business days 90.0% of the time. Measured based on the DXC Service Management (SM) ticket open/closed times. Using SM ticket times does not include actions taken by non-security administration staff.
TARGET	90.0% within 5 business days
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #28	**Key Staff**
DESCRIPTION	The contractor must have the required number of key staff positions hired and working within 60 calendar days of the vacancy for the contractor's operations at the Vermont location. Refer to the contract for the list of key staff.
TARGET	100% within 60 calendar days of vacancy
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	$200/day out of compliance per key staff

SLA #29	System Changes
DESCRIPTION	All system changes (Change Requests or Specification Orders) must perform as the State of Vermont expects based on their business rules, specifications, and directions. The State of Vermont change requester (state sponsor) has the opportunity to review DXC's test plan and test results prior to implementation. If either DXC or the SOV discovers that the system change is not working as intended, they will notify the other party regarding this SLA.
TARGET	100% of system changes are implemented and perform as intended
EXCEPTIONS	If the State of Vermont change requester (state sponsor) is given the opportunity but does not review DXC's test plan and test results prior to implementation, the result of failure to meet the target will be reduced to $250/occurrence.
RESULT OF FAILURE TO MEET TARGET	$500/occurrence. 20% recoupment of the total CSR-related hours invoiced to that deliverable. The correction(s) needed for the system change will be performed by DXC without additional cost to the SOV.
SLA #30	**Incurred Fees & Penalties**
DESCRIPTION	The contractor must not allow the State to incur fees, fines, penalties or federal financial participation (FFP) losses or reduction per federal law, rules or regulations, or actual expenses in recouping funds or property from a third party, due to an error or oversight by the contractor (system or human error).
TARGET	100% free of incurred fees or penalties
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	$500/occurrence plus damages
SLA #31	**1099 Files**
DESCRIPTION	The Contractor must submit timely and accurate 1099 files to the IRS by January 31st each year.
TARGET	100% by January 31st
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	The amount imposed by the IRS for each and every individual incident.
SLA #32	**Client Communication**
DESCRIPTION	The Contractor must acknowledge State requests and inquiries within 1 business day. A solution is not required in 1 business day, however, an estimate of the time required to determine the solution should be offered to the client. This service level applies to online form submissions and group email inboxes including, but not limited to:

	Agency Requests, Analytics Team, Reference Team, and the Enrollment Team.
TARGET	95.0% within 1 business day
EXCEPTIONS	This service level does not apply to email requests or inquiries sent to an individual contractor staff's email.
RESULT OF FAILURE TO MEET TARGET	Cumulative Credit
SLA #33	**Service Level Reporting**
DESCRIPTION	The Contractor must measure and report on 100.0% of all SLAs by the 15th calendar day of the following month after the end of the reporting month. SLAs will be measured based on a month's worth of service activity which was fully measurable by the end of the reporting month. The SLA reporting (dashboard & detailed reports) will be available by the 15th calendar day of the following month after the end of the reporting month.
TARGET	100.0% within specified timelines
EXCEPTIONS	None
RESULT OF FAILURE TO MEET TARGET	$1,000 per month

3. Exhibit 4 (Electronic Visit Verification Solution Statement of Work) is hereby deleted and replaced with the following Exhibit 4:

Exhibit 4
Electronic Visit Verification Project
Scope of Work

1. Electronic Visit Verification (EVV) Project

This Scope of Work (SOW) is made subject to and will be governed by the terms and conditions of the January 1, 2017 Contract between the State of Vermont, Department of Vermont Health Access ("the State") and DXC Technology Services LLC (the "Contractor"). This SOW defines the work to be performed, the responsibilities of the parties, and key assumptions and terms guiding the implementation project (the "Project") for delivery of the EVV Solution (the "Solution"). Contractor will partner with the leading EVV Software Vendor, Sandata Technologies, LLC (the "Supplier") to implement a software-based services solution to support the State's compliance with the CURES Act. The term of this SOW is no later than 4 months from date of signature through end date of this Contract.

2. Purpose and Scope

The purpose of the project is to assist the State in complying with Section 12006 of the 21st Century CURES Act, which was passed by the U.S Congress in December 2016 and mandates States to implement EVV solutions for defined personal care services by January 1, 2020. Non-compliance of the requirements can lead to a reduction in the Federal Medical Assistance Percentage (FMAP) for the associated personal care services.

Table 1 below summarizes the Software as a Service (SaaS) modules, MMIS feature enhancements, and implementation services planned for deployment as a result of recent scoping discussions with State leaders. Items listed as optional may be added to the overall scope. At this time, all items are included in the Table A EVV Implementation / Operations budget in the EVV Project section of Attachment A.

Table 1. State Selected EVV SaaS Modules, MMIS Features, and Services

SaaS Module, MMIS, Feature, or Implementation Service	In Scope
Sandata Mobile Software and Telephone Services Includes both telephonic-based services and mobile application for IOS and Android to allow recording of visits by caregivers. Sandata recommends a "Bring your Own Device and Data Plan" model where the providers are responsible for providing caregivers with devices for use with Mobile Visit Verification. EVV will be used by members receiving care from Provider Agencies and Consumer Direct program	Yes
Sandata Santrax Provider and Fiscal Agent Portals Module Web based provider portal for providers to review and make corrections to visit data and includes a 'provider' portal for the Consumer Direct Program fiscal agent.	Yes
Sandata Santrax Jurisdictional View (JV) Portal Module Read only portal for the State and Contractor to review and report on program information.	Yes
Sandata Santrax EVV Aggregator Module Allows providers to use and pay for their own third party EVV systems, while integrating all third party EVV data for view by the Contractor and the State. Data in the Aggregator is normalized across all EVV vendors to provide an accurate view of visit verification, regardless of source system.	Yes
MMIS Claims Validation Services Ensures the appropriate business rules are defined for matching claims and EVV Aggregator Data via post-payment review reporting and business processes, and/or via MMIS claims edits within the MMIS adjudication process.	Yes
Sandata Consumer Directed Care (CDC) Portals Module In addition to the standard EVV portal for the Contractor to monitor the Consumer Direct program EVV activity, the State can choose to deploy additional EVV portals for participants and their caregivers to allow them to manage, edit and approve their EVV created timesheets.	Yes
Sandata CDS Data Interface for CDC Module If the Consumer Directed Care Additional Portals is selected, then this additional data exchange from the Contractor will be needed to support management of participant and caregiver portal access.	Yes

Training Services See section 3.6 Training for EVV Software Services for definition of custom webinar-based training services for Vermont implementation of Sandata Santrax modules	Yes
Certification Support Services The State may authorize additional Contractor work for support of CMS certification activities, based on written and State approved Specification Orders. Specification Orders will be developed and proposed by the Contractor and approved by the State. Existing deliverables and activities included in the scope of the Contract will be excluded from scope of certification Specification Orders.	Optional
EVV Customization Services The State may authorize additional Contractor work for support of customizations to SaaS EVV modules and/or MMIS software, based on approved Specification Orders in support of the State's compliance with the CURES act.	Optional

3. Solution Requirements

The Contractor will deliver the Solution, which will be utilized by providers, the State, and the Contractor. The Solution is comprised of the following services:

3.1. EVV Software Services

The following software modules are delivered and maintained as a Software as a Service (SaaS) made available via the Internet. The SaaS provides all hosting, software updates, and software support for the following software components as part of this service:

- Electronic Visit Verification;
- Provider EVV Portal;
- Consumer Directed Care Fiscal Portal;
- Consumer Directed Care Additional Portals
- Jurisdictional View Portal; and
- EVV Aggregator.

3.1.1. Electronic Visit Verification

The Electronic Visit Verification service captures all of the following data elements required for 21st Century Cures Act compliance:

- Member ID
- Caregiver ID
- Service Type
- Service Date
- Service Start and End Time
- Service Location

In addition, the EVV service captures the following additional data elements:

- Tasks
- Member verification of time of visit and services provided

3.1.2. The following EVV component options support capture of visit verification data:

- Telephone Visit Verification™ ("TVV™") – TVV uses Automatic Number Identification ("ANI") technology to validate telephone calls to record visit data in near real time.
- Includes two U.S. based toll-free telephone lines for providers to record services provision data twenty-four (24) hours per day, seven (7) days per week, excluding downtime for routine system maintenance.
- Sandata Mobile Connect™ – Americans with Disabilities Act Section 508 compliant application for mobile devices. Sandata Mobile Connect uses GPS technology, verifying location via GPS enabled devices (mobile phones).
- Providers shall use their own mobile devices to download the EVV mobile application and their own data plans to transmit visit transactions.
- Provider devices must conform to published minimum device specifications and direct care providers must have an appropriate mobile communication plan in place to utilize Sandata Mobile Connect.
- The SaaS product routinely makes available functionality to meet the needs of customers. For the Sandata Mobile Connect application, as new releases become available, they are published to the respective stores (IOS or Android) and users are automatically prompted to download the latest version of the application

3.1.3. Both TVV and Sandata Mobile Connect will be provided in the following languages: English, Spanish, Russian, Somali, Mandarin Chinese, and Egyptian Arabic.

3.1.4. Provider EVV Portal and Consumer Directed Care Fiscal Portal

The Provider EVV Portal and Consumer Directed Care Fiscal Portal, are web-based services for authorized provider and the Contractor log-on and data entry. The Fiscal Agent role of the Contractor for EVV access purposes, is defined as the entity contracted by the State to manage the consumer-directed care program.

3.1.5. The Provider EVV Portal and Consumer Directed Care Fiscal Portal shall support the following functions:

- Provide log-on and access to designated staff and to designated providers and the Contractor. Administrative terminal functionality shall include multi-level access controls to ensure that only authorized individuals can process administrative transactions or access member account information through administrative terminal.
- Provide the ability to maintain data including but not limited to the following records for tracking direct care providers, client/member, and visit information: recipient first name and last name; recipient telephone number; recipient address; recipient Medicaid ID; Direct Care worker ID; Direct Care worker first and last name; service provided; service date; service start and end time; service location; tasks; and visit status (i.e. in process, incomplete, verified, processed, omit).
- A record will be created in the database whenever any of the following actions occur:
  - A check-in is successfully completed by a direct care provider
  - The record shall be amended at the check- out to add the check-out time
  - A record will be created in the database whenever a successful check-out is completed
- The EVV Provider Portal and Sandata Consumer Directed Care Fiscal Portal will record any exceptions that occurred on the visit. The Contractor will work with the

State to review and agree on the exceptions based on the configurable exception options which include:
  - Client Signature Exception
  - GPS Distance Exception
  - Missing Service
  - Service Verification Exception
  - Unknown Client
  - Unknown Employee
  - Unmatched Client ID/Phone
  - Visit Verification Exception
  - Visits without in calls
  - Visits without out calls
- Provider entry or edit of visit data: For certain service encounters, Providers will use the EVV Provider Portal or Consumer Directed Care Fiscal Portal to enter data into the system. Data entry and/or edits to service encounter information are allowed only for certain defined and pre-approved circumstances for which documentation of service delivery and reason for manual entry or record edit exists. Optional comments may also be entered for manual edits. The service shall also show to the provider or fiscal agent the equivalent duration for the times entered and required reason codes for changes.
- The Contractor will work with the State to review and agree upon the list of reason codes.
- The EVV Portal and Consumer Directed Care Fiscal Portal include the ability to receive data from import files formatted using standard specifications for authorizations, clients/members, providers, and member/direct care worker crosswalk for the consumer directed population (if the Consumer Directed Recipient and Caregiver EVV Portals are selected). Authorization data will be used to determine the provider agency that is providing services to the client/member and will allow that member Information to reside in that provider's EVV system.
- If data is not made available via imported files, the Provider EVV Portal or Consumer Directed Care Fiscal Portal allow for manual data entry of this information by the providers or fiscal agents. The Contractor will work with the State to define the policy regarding the usage of these manual data entry features.
- Providers or fiscal agents with appropriate roles-based access will have the ability to enter direct care provider information. Direct care provider information shall include the following:
  - Direct care provider first and last name
  - Direct care provider ID
  - Start Date
  - Termination date
  - Record creation date
  - User creating record
  - Last update date
  - Last updated by
- The system records include an audit trail of manually entered information including:
  - User name
  - Date of entry

- The Provider EVV Portal and Consumer Directed Care Fiscal Portal allow providers and fiscal agents to run standard reports.
- During the implementation, the Contractor will work with the State to configure roles-based access to the EVV applications based on State business rules. The business rules document shall be the deliverable reviewed and accepted by the State for capturing authorization configurations for EVV applications.

3.1.6. Consumer Directed Care – Additional Portals

- In addition to the standard EVV portal or the Fiscal agent to monitor the Consumer Direct program EVV activity, the State can choose to deploy additional EVV portals for participants and their caregivers to allow the State to manage, edit, and approve their EVV created timesheets.
- Includes portal for viewing, editing, and approving visit data for participants and caregivers.
- Include specific EVV system configuration for the Consumer Direct EVV program.
- Includes the following training activity for the Consumer Direct fiscal agent (CDS) to support them training and providing Tier 1 support for Consumer Direct EVV users:
  - Five consecutive days of trainer classroom training for designated CDS staff;
  - Onsite classroom training does not include computer rental and facility charges for each classroom training session and must be provided by the State.

3.1.7. Sandata Jurisdictional View Portal

- The Jurisdictional View service shall support the following functions:
  - Each EVV recipient is set up in the system and assigned to the authorized Provider. Authorized State users can filter and run reports to show all system activity related to recipients.
  - The Jurisdictional View service shall include real-time web interface reporting and online screen display of service delivery encounters. Display of data from the Provider accounts is for viewing parties specified by the State, for monitoring of service delivery.
  - Standard reports shall be available. All reporting shall be available on-demand and reports can be printed or downloaded electronically, in .PDF, Excel, and .CSV formats.

3.2. Data Exchange with EVV Software Services

3.2.1. The State shall provide the following data files using the Contractor's standard data specifications:

- Member File
- Authorization File
- Provider Agency File

3.2.2. The CDS Fiscal Agent, shall provide the following data files using the Contractor's standard data specifications:

- Employee File
- Employee/Member Crosswalk File

3.2.3. The CDS Fiscal Agent shall receive the following data files using the Contractor's standard data specifications:

- Export of Visit Data to Fiscal Agent
- Export of Approved Visits for Payroll

3.2.4. The Contractor will provide the latest versions of the above Contractor's standard data specifications before the analysis and design phase begins. The Contractor will participate in meetings with the State to understand the data exchange requirements contained in the latest versions of the specifications.

- The Contractor will participate in meetings with the State to understand the data contained in the latest version of the data warehouse export specification.
- The Contractor will load the EVV data extract, into the MMIS EVAH data warehouse database, for subsequent program monitoring and assurance purposes by the State.

3.3. Sandata Aggregator

3.3.1. The Contractor will support third party provider interfaces that send third party EVV data to the Sandata EVV Aggregator using the Contractor's standard third party interface specification.

3.3.2. The Contractor will work with the State to determine the data elements required in the Aggregator and update the Third-Party Interface data documents to reflect those interface requirements.

3.3.3. The following process will be followed to complete all interface work:

- All Providers who select to use a third-party interface must first register during the implementation process. At that point, the Provider receives their testing credentials
- All Providers must execute certain documents, such as a Business Associate Agreement, Data Use Agreement, and Application Program Interface (API) License Agreement, prior to use of the interface.
- The Provider is responsible for correcting all errors and sending a revised file to retest.
- Once the Provider interface passes the automated testing, the interface is approved for production. At that point, the Provider receives their production credentials.

3.4.MMIS Claims Validation

3.4.1. The Contractor will work with the State to ensure the appropriate business rules and data exchange requirements are identified to support matching claims and the resulting EVV Aggregator Data in the MMIS, via post-payment review reporting and/or via MMIS claims editing as directed by the State.

3.4.2. The Contractor will implement new edits to match the EVV visit to the claim submitted for payment based on State defined rules after sufficient adoption of EVV. Thus, MMIS claims editing will not be enabled at time of initial EVV go-live for State programs.

3.4.3. The Contractor will use the EVV Aggregator data for claims processing and/or claims reporting and will make EVV data available for use by State data analysts via the MMIS data warehouse and Business Objects query tool.

3.5.Environments

3.5.1. The Contractor will create the following environments as part of the implementation process:

- Development-level test environment for Contractor testers to deploy target builds and perform integration, data interface testing, and regression testing.
- Contractor will provide a test environment for User Acceptance Testing to be performed by the State.
- Upon completion of User Acceptance Testing, Contractor will provide a training environment support all EVV Training.

3.6.Training for EVV Software Services

The following table summarizes the training provided as part of the initial implementation of EVV Services.

Table 2 – Scope of Training

Training Method	Training Plan
CDS Employee and Employer webinars	Fifteen (15) total instructor led webinars
Consumer Direct Fiscal Agent Train the Trainer Sessions	Five (5) days of classroom training

3.6.1. The Contractor will be responsible for working with the State to define a training plan during the implementation process, to support implementation training and roll out.

3.6.2. The Contractor will provide electronic training materials in English only. The types of documentation materials available include:

- System Users Guides
- E-learning Training Content
- Quick Reference Guides / Cards
- Training Plans
- Training Decks, suitable for onsite instructor led or webinar

3.6.3. The Contractor will provide a separate training environment for Provider and fiscal agencies. New users may access the training environment through a secure web portal. The training environment may be used for program launch training, for all major releases, and for training of newly hired provider or State staff after go-live. The training environment will remain available throughout the life of the program for Providers and fiscal agencies to continue to train their staff and members. It will always be kept updated to the level of the production environment

3.6.4. The Contractor will deliver EVV training to provider agencies and Jurisdictional View users.

3.6.5. Onsite classroom training does not include computer rental and facility charges for each classroom training session; training facilities will be provided by the State. Facility reservation, coordination, or payment for facilities or training equipment is outside the scope of this contract and is the responsibility of the State.

- Five (5) consecutive days of Train the Trainer for up to 10 Self-Directed Fiscal Agent attendees in the Train the Trainer session.
- Fiscal Agents or designees will be responsible for providing all outreach and training to Members and Caregivers participating in the Self-Directed care program.
- A Learning Management System will be provided that can be accessed for independent training during implementation and post go-live.
- A recording of VT instructor-led webinar training will be posted to Sandata's Learning Management System for those Self-Directed Employers/Designees and Self-Directed Employees who do not participate in the live webinar sessions.
- Direct Member or Caregiver training by the Contractor. Trainings will be scheduled as agreed upon through the implementation project for fifteen (15) total instructor led webinars for CDS employees and/or employers.

- Contractor will provide webinar information to be used in the State registration announcement.
- Contractor will deliver attendance reports following each webinar which will include list of participants who logged into the webinar. Attendance report will include participant's first and last name, email address, the course name, and date completed.
- Training materials will be made available to Provider Agencies and Fiscal Agents to share with their caregivers and/or members to support the training activities.
- Additional Contractor-led training may optionally be provided, at an additional cost via an authorized Specification Order.

3.6.6. All training materials and delivery are available in English; if additional languages are required for training delivery, additional fees will apply.

3.7. Operations and User Support for EVV Software Services

3.7.1. For the SaaS product, there are releases functionality to meet customer requirements.

3.7.2. There are periodic releases for the services to ensure that the service continues to meet the latest standards and regulations.

3.7.3. Users are notified in advance of all scheduled releases.

3.7.4. For the Sandata Mobile Connect application, as new releases become available, they are published to the respective stores (IOS or Android) and users are automatically prompted to download the latest version of the application.

3.7.5. Contractor's EVV System up time Service Level is 99.9%, not including scheduled downtime. Contractor will report system up time to the State monthly.

3.7.6. The Contractor will provide Tier 1 (initial point of contact) and Tier 2 (escalated technical support) Customer Care help desk support to providers and Jurisdictional EVV users.

3.7.7. Customer Care services will be provided in English only.

3.7.8. The Customer Care help desk will have live agents available during normal business hours of 8 am to 5 pm Eastern Time, Monday through Friday, except for the observed holidays as reflected below:

- New Year's Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Christmas

After Hour Support: For system outages, a customer care caller can activate immediate after-hours support for outage resolution. For non-urgent needs, callers can leave a message which will be returned the next business day.

3.7.9. When the Self-Directed Recipient and Caregiver EVV Portals are implemented, the Fiscal Agent (s) shall be responsible for providing Tier 1 support to all Members and Caregivers participating in the Self-Directed Care Program.

- "Tier 1 Support" means support services provided by the Fiscal agent's help desk personnel: (a) to answer questions regarding the use or operation of the system and (b) to report errors within the system.

- It is assumed and the pricing in this SOW is based on the fact that a minimum of 90% of customer Care calls will be handled by Fiscal Agent Tier 1 by no later than 6 months post system go live. If this percent of Tier 1 calls is not achieved by such date, then Contractor reserves the right to reevaluate the Customer Care plan and fees. Measurement would be based on "Total EVV support calls from Fiscal Agent divided by total EVV support calls to Fiscal agent".

4. Implementation Requirements

This section further elaborates on aspects of the Implementation of the EVV Solution, in addition to those implementation activities explained in the Solution Requirements section above. The following approach requirements are the basis for the project work plan, scope, and associated costs models. If any of these items are determined to be incorrect or invalid, then the resulting impact will be assessed and resolved through the State's change control process.

4.1. Implementation Project Assumptions

4.1.1. Recent CMS guidance was issued requiring a streamlined Certification process. Adjusted criteria will be applied as directed by CMS, which may vary from the certification requirements identified in this section.

4.1.2. The technology meets the CMS certification checklist criteria as described below:

Table 3 – Certification Criteria

MITA Ref #	System Review Criteria	Solution Meets Criteria
PE.PI1.22	The electronic visit verification (EVV) module captures, tracks, and verifies data with respect to personal care services or home health care services, including: • Type of service performs • Individual receiving the service • Date of service • Location of service delivery • Individual providing the service, and • Time the service begins and ends.	Yes
PE.PI1.23	The EVV module is configurable to support multiple programs or services which have different policies, procedures and business rules, all of which are subject to change during the contract period.	Yes
PE.PI1.24	The EVV module is able to receive information in batch and individual transactions.	Yes
PE.PI1.25	The EVV module verifies visit components within program requirements when the direct care worker initiates the visit verification. Each visit initiated through the EVV should be captured, whether or not the visit is verified.	Yes
PE.PI1.26	The EVV modules requires providers to attest to the presence of hard copy documentation for any manual visit verification.	Yes

PE.PI1.27	Providers are able to submit necessary verification information via alternate methods, should the primary mode of submission be out of service. (For example, if a handheld device is not working properly, the provider is able to phone in the visit information or submit it via a website portal).	Yes

4.1.3. The Contractor assumes a "Bring your Own Device and Data Plan" model where the providers or caregivers are responsible for providing devices and data plans for use with the Sandata Mobile Connect application.

4.1.4. The scope of system configuration activity will consist of setup, configuration, and validation of EVV portal for up to sixteen (16) Provider Agencies and one (1) Consumer Direct Fiscal Agent.

4.1.5. Operations Phase work begins when the Solution goes live through the end of the SOW term.

4.2. Project Timeline

4.2.1. The project start date will be mutually agreed upon in writing by both Parties.

4.2.2. Once agreed upon and baselined, changes to the Project Plan schedule will be resolved through the State's change control process. It shall be the joint responsibility of the State and Contractor to monitor the project schedule and take steps deemed reasonable to avoid schedule non-compliance.

4.2.3. Assuming Contract changes are not requested, the Project Plan will indicate completion of implementation of the Deliverables approximately four (4) months from the implementation start date, plus any time required for optional services such as added days for User Acceptance testing.

4.2.4. User Acceptance Testing (UAT) will occur during a pre-defined fifteen (15) business day period during the implementation project and will be based upon pre-defined testing scripts provided by the Contractor and/or the State. Optionally, the State may select one or more additional weeks of UAT time at additional project cost.

4.2.5. Test scripts provided by the Contractor will be written and customized against the defined business rules document to test the State of Vermont's implementation. The test cases will be included in the Requirements Traceability Matrix. The test cases will also be provided to the State for review and comment prior to UAT Execution.

4.3. Implementation Deliverables

4.3.1. At the request of either Party, the Contractor will provide a Deliverables Expectations Document (DED) for any deliverable or work product described within Attachment A of this Contract. A DED is a document that provides the organizational outline for production of the associated deliverable and describes the content of each section in the associated deliverable.

4.3.2. EVV Software Services configured for use by State and its program providers.

4.3.2.1. Project Management Plan (PMP). A PMP shall be used to manage project execution. The PMP documents the actions necessary to define, prepare, integrate, and coordinate the various planning activities. The PMP defines how the project is executed, monitored and controlled, and closed. It is progressively elaborated by updates throughout the course of the project.

4.3.3. Project Schedule. An initial implementation project schedule (the "Project Schedule") will be agreed and finalized as part of the implementation process and will be updated throughout the implementation process as agreed to by both parties.

4.3.4. A comprehensive outreach strategy and recommended documents to support outreach to ensure all stakeholders are knowledgeable about the new EVV program and Contractor's solutions.
4.3.5. Status Reports. Weekly written status reports will summarize the tasks and activities performed for that time period, activities proposed to be completed in the next time period, and any risks and issues that need to be escalated and tracked.
4.3.6. Requirements Analysis Sessions. As part of the implementation process, the Contractor will conduct business review meetings with the State. Attendees of these meetings include Subject Matter Experts on program operations from the Customer and Contractor staff, State Business Analysis staff, as well as the Technical Lead and the Implementation Manager. The Technical Lead and the Implementation Manager lead these guided sessions to review program policies as well as EVV system functionality and configurability. During these sessions the program rules and corresponding system configurations will be documented. Evidence of these sessions will be provided in the form of meeting minutes.
4.3.7. Business Rules Document. A Business Rules document which includes implementation decisions, must be reviewed and accepted by the State prior to configuration of software services.
4.3.8. Data Exchange Specifications Documents. Once the Business Rules Document is completed and approved, a Data Specifications document will be created which describe all of the data exchanges required to support the program. In addition to the Contractor's standard data specifications content, Vermont data-specific decisions will be documented. These specifications documents must be reviewed and accepted by the State prior to configuration of software services.
4.3.9. User Acceptance Test Plan. The State will produce a User Acceptance Test Plan document, with input by the Contractor. The UAT Plan will include roles and define the test strategy for all selected modules as identified in section 2 table 1. UAT testing will be based on predefined test scripts provided by the Contractor and reviewed by the SoV.
4.3.10. Integration Test Plan. An Integration Test Plan will be created by the Contractor for review and acceptance by the State, for data exchange between the modules and other SoV applications (including MMIS). The Integration Test Plan will identify Contractor and State roles and testing strategy for data interfaces, based on the Contractor's standard testing process.
4.3.11. User Acceptance Test Scripts and Results. Test scripts provided by the Contractor will be customized to validate State-specific rules and configuration of the selected modules. Test scripts will be provided for review by the State prior to UAT execution of the test scripts. The Contractor will provide summarized results of its own test execution.
4.3.12. Contractor will demonstrate traceability of the test scripts to documented Vermont needs as identified within the implementation deliverables Business Rules and Data Exchange Specifications. A final Requirements Traceability Matrix (RTM) will be delivered following UAT Execution and reconciliation of bugs/defects/incidents and prior to system acceptance.
4.3.13. Training Plan. The Contractor will collaborate with the State in development of a training plan. The training plan will identify agencies and user groups to be trained, will identify the scope of training for State-specific use of modules, and will identify the schedule for training.

4.3.14. Training Manuals. The Contractor will develop all training materials for agreed upon training modalities, as described in the "Training for EVV Services" section above.
4.3.15. Training sessions. Evidence of training performed, as identified in the section above "Training for EVV services", will be provided in the form of training registration artifacts identifying what persons registered or attended training sessions.
4.3.16. Payments for implementation milestone fees will be made based on the completion and State approval of the following key deliverables/milestones:

Implementation Milestones	**Payment % of Total Fixed Price**
Kick off Meeting and Project Plan Approval of EVV System	25%
Approval of Business Rules for EVV System	25%
Acceptance of Contractor User Acceptance Testing for EVV System	13%
Validation by State of User Acceptance Testing for EVV System	12%
EVV System Deployment	25%

4.3.17. Payments for EVV State-authorized Specification Orders are not to exceed the Certification and Customization services budgets established by this Contract. Payments will occur for each completed and approved Specification Order based on the costs proposed by the Contractor and agreed to by the State. Scope of Specification Order(s) for EVV certification support shall exclude project deliverables and activities already provided for by the Contract.

4.3.18. Invoices will be sent only after State approval of the applicable milestone, deliverable, or services as defined within this contract or approved Specification Order. Payment for approved services/milestones shall be made in accordance with Attachment B Payment Provisions.

4.4. Acceptance for Deliverables
4.4.1. All deliverables and work products described within Attachment A of this Contract are subject to review and approval by the Authorized Representative of the State or designee(s) prior to being accepted. Payment shall not be made until a deliverable or work product is formally accepted and approved. Deliverables are considered approved when the State issues a Deliverables Acceptance Document (DAD) signed by the State's authorized representative.
4.4.2. The State's deliverable management process will be followed for review and acceptance of project documentation deliverables. Written deliverables submitted for State review and acceptance shall be responded to by the State within ten (10) business days. The Contractor shall respond within five (5) business days to any written feedback received on each deliverable, and the State shall then have up to an additional five (5) business days to provide written acceptance of the deliverable.
4.4.3. Should State reviewers determine that a deliverable does not meet expected minimal quality standards and/or content expectations as specified in the Deliverables Expectations Document (DED), the State may reject the deliverable without performing a complete review. In this instance the deliverable submission will be considered as

voided, i.e., the State will have ten (10) business days to review the next submitted revision and the project schedule will not consider the original version to have been submitted.

4.4.4. Should the deliverable be deemed acceptable, but issues arise after a DAD is signed by the State, collaborative working sessions will be initiated to determine a solution, and the Contractor shall implement the solution at no additional cost to the State.

4.5. Project Management Responsibilities.

4.5.1. The State will appoint a State Project Manager for the Implementation phase. This may be a leader who is already engaged with other projects for State of Vermont. The State Project Manager will coordinate the activities and tasks to be performed by the State and its other business partners.

4.5.2. The Contractor will appoint, subject to State review, an experienced implementation leader to perform the role of Contractor Project Manager. This may be a leader who is already engaged with other projects for State and who will be fully accountable for overseeing delivery including the work of the subcontract software Vendor.

4.5.3. The Contractor will provide a full-time software project manager to lead the EVV implementation. The software project manager is responsible for participating in project meetings, and for providing meeting agendas, meeting minutes, and creation and maintenance of the implementation project plan.

4.5.4. The Contractor will provide EVV System configuration and testing resources who will configure the system and perform system and integration tests based on the agreed upon System and Integration test plan.

4.5.5. The Contractor will provide resources to support system, integration, and user acceptance testing phases.

Appendix II

Attachment B, Payment Provisions beginning on page 60 of 106 of the base agreement, and as previously amended, is hereby deleted and replaced with the following Attachment B:

ATTACHMENT B
PAYMENT PROVISIONS

The maximum dollar amount payable under this contract is not intended as any form of a guaranteed amount. The Contractor will be paid for products or services actually delivered or performed, as specified in Attachment A, up to the maximum allowable amount specified on page 1 of this contract.

1. Prior to commencement of work and release of any payments, Contractor shall submit to the State:
    a. a certificate of insurance consistent with the requirements set forth in Attachment C, Section 8 (Insurance), and with any additional requirements for insurance as may be set forth elsewhere in this contract; and
    b. a current IRS Form W-9 (signed within the last six months).
2. Payment terms are **Net 30** days from the date the State receives an error-free invoice with all necessary and complete supporting documentation.
3. Contractor shall submit detailed invoices itemizing all work performed during the invoice period, including the dates of service, rates of pay, hours of work performed, and any other information and/or documentation appropriate and sufficient to substantiate the amount invoiced for payment by the State. All invoices must include the Contract # for this contract.
4. Contractor shall submit invoices to the State in accordance with the schedule set forth in this Attachment B. Contractor invoices shall be submitted no more frequently than monthly, but no later than quarterly. For services set forth in Sections I and II of Attachment A, the Contractor shall submit monthly invoices not to exceed $1/12^{th}$ of the annual amount listed in the Fixed Price subtotal of Table B.1 this Attachment B. Invoices for services set forth in Section III of Attachment A shall include the number of hours worked by employee during the specified billing period and the total amount billed, and reference the specific project being billed. Invoices shall reference this contract number, include date of submission, invoice number, amount billed for each scope of work, total amount billed, and be signed by the authorized representative of the Contractor.
5. No benefits or insurance will be reimbursed by the State.
6. Invoices and any required reports shall reference this contract number and be submitted electronically to: AHS.DVHAInvoices@vermont.gov
7. The total maximum amount payable under this contract shall not exceed $85,405,203.40
8. **MMIS Operations**
    A. The following Operational Invoice Payment Schedules depict the maximum amounts payable to the Contractor for MMIS services as set forth in Attachment A, Sections I and II,

to this Contract based on claims processing volume parameters, known as "base services". The Contractor shall invoice the State monthly for 1/12th of the annual fixed price amounts listed in the fixed price subtotal of the table below. The Contractor shall invoice the state monthly for bill as utilized services. This table does not include project costs shown in Table B.5 for which the Contractor shall invoice separately.

Table B.1 – Operational Payments

FIXED PRICE	1/1/17 –12/31/17	1/1/18-12/31/18	1/1/19-12/31/19	1/1/2020 - 12/31/2020	1/1/2021 - 12/31/2021	Maximum 5 Year Operations Cost
Provider Enrollment	$1,546,698.54	$1,569,899.01	$3,097,852.29	$2,672,813.99	$2,687,309.09	**$11,574,572.92**
Financial Management	$1,036,424.46	$1,051,970.82	$1,117,852.07	$1,114,011.59	$1,122,719.46	**$5,442,978.40**
Operations Management	$3,264,964.42	$3,313,938.88	$3,521,479.27	$3,509,380.92	$3,536,812.60	**$17,146,576.09**
Drug Payment Transactions	$583,300.72	$592,050.24	$629,128.27	$626,966.84	$631,867.64	**$3,063,313.71**
Plan Management	$1,195,339.85	$1,213,269.94	$1,289,252.79	$1,284,823.45	$1,294,866.50	**$6,277,552.53**
Provider Management	$697,809.25	$708,276.39	$752,633.26	$750,047.52	$755,910.39	**$3,664,676.81**
MES IT Support	$2,216,483.24	$2,249,730.49	$2,390,623.24	$1,882,410.04	$1,901,032.56	**$10,640,279.57**
MES System	$2,829,273.57	$2,871,712.67	$3,051,557.99	$3,041,074.09	$3,064,845.17	**$14,858,463.49**
EVV Support Service	$0.00	$0.00	$0.00	$87,280.00	$87,280.00	**$174,560.00**
EVV Monthly Min Visit Fees	$0.00	$0.00	$0.00	$65,249.55	$65,249.55	**$130,499.10**
Fixed Price Subtotals	**$13,370,294.05**	**$13,570,848.44**	**$15,850,379.18**	**$15,034,057.99**	**$15,147,892.96**	**$72,973,472.62**
Billed as Utilized						
EVV Recurring Visit Fee Over Min	$0.00	$0.00	$0.00	$65,249.33	$65,249.33	**$130,498.66**
EVV Recurring Aggregator PMPM	$0.00	$0.00	$0.00	$41,237.11	$41,237.11	**$82,474.22**
CSR Hours	$0.00	$0.00	$0.00	$500,000.00	$500,000.00	**$1,000,000.00**
Postage	$108,000.00	$108,000.00	$108,000.00	$108,000.00	$108,000.00	**$540,000.00**
Additional Space	$0.00	$0.00	$0.00	$54,000.00	$54,000.00	**$108,000.00**
Maximum Annual Spend	**$13,478,294.05**	**$13,678,848.44**	**$15,958,379.18**	**$15,802,544.43**	**$15,916,379.40**	**$74,834,445.50**

B. Volume Accounting and Reconciliation

Table B.2 - Volume Parameters

VOLUME PARAMETERS	Claims Processing	EDI Transactions
High Estimate	9,000,000	35,000,000
Median Estimate	6,000,000	25,000,000
Low Estimate	4,500,000	15,000,000

i. Claim volume accounting and reconciliation of changes in Contractor reimbursement

The following definitions of a claim delineate between claim types, and shall apply to administrative claims processing adjudication counts tracked and reported by the Contractor:

a. For all institutional based services (Hospice (H), Inpatient/Outpatient (I/O), Home Health (Q), Institutional Crossovers (W,X), Nursing Home (N), a claim is a paper document and EMC (X12N) record of services rendered during a statement period or date range for which there are one or more service, accommodation, HCPCS and/or ancillary codes.

b. For all professional based services (Dental (L), Physician (M), Vision (P), Professional Crossovers (Y), a claim is a line item on paper document or an EMC (X12N) record of services rendered for a service date(s) for which there is a service code.

Financial Adjustment

c. Claim Transactions: The total amount payable each year shall remain fixed unless the claims volume falls outside the estimated parameters for that year. Should the actual claims volume, for a given year, fall outside the estimated parameters, a year-end financial adjustment to the amount payable for operations for that year may be made using the following process:

d. A unit value will be calculated by dividing the Operations Management price for the applicable year by the midpoint claims estimate for that year.

e. If the actual claims volume falls below the low estimate claim parameter, the Contractor shall reimburse the State a portion of the fixed price per the following calculation:

Low Claims Volume Estimate minus **Actual Claims Volume** x 40% of the calculated unit value for the same contract year.

f. If the actual claims volume exceeds the high claims parameter for the contract year, the State will make an additional payment to the Contractor per the following calculation:

Actual Claims Volume minus **High Claims Volume Estimate** x 40% of the calculated unit value for the same contract year.

An adjustment in the fixed price payment to the Contractor for operations shall depend on verification and certification that actual claims volume counts are accurate and consistent with the definition of a claim as set forth in this section B.i.

Financial Adjustment

ii. EDI Transaction volume accounting and reconciliation of changes in Contractor reimbursement

The following definition of an EDI transaction shall apply to counts tracked and reported by the Contractor:

Table B.3 – Transaction Measurement Rules

Transaction	Guideline
837 transactions	Counts are based on the number of CLM segments.
835 transactions	Counts are based on the number of CLP segments.
834 transactions	Counts are based on the number of INS segments.
820 transactions	Counts are based on the number of 2100B: ENT for members. For organizations the count is based on 2100A: ENT
270 Batch transactions	Counts are based on the number of 2100C:NM1 name segments.
271 Batch transactions	Counts are based on the number of 2100C:NM1 name segments.
270 Interactive transactions	Counts are by transaction, as each 270-interactive transaction contains only 1 member.
271 Interactive transactions	Counts are by transaction, as each 270-interactive transaction contains only 1 member.
276 Batch transactions	Counts are based on the number of 2200D: TRN claim status tracking number segments.
277 Batch transactions	Counts are based on the number of 2200D: TRN claim status tracking number segments.
276 Interactive transactions	Counts are by transaction, as each 276-interactive transaction in contains only 1 claim status request.
277 Interactive transactions	Counts are by transaction, as each 276-interactive transaction in contains only 1 claim status response.
278 transactions	Counts are based on the number of ST segments.
999 transactions	Counts are based on the number of 999 response files.
TA1 transactions	Counts are based on the number of TA1 response files.
277CA transactions	Counts are based on the number of 2200D: TRN claim status tracking number segments
277U transactions	Counts are based on the number of 2100D NM1 name segments. If the count is less than 1, then the count is based on the number of 2200D TRN segments in the transaction set.
HTML report (Readable acknowledgement)	Counts are based on the number of 999 response files (source for HTML file).
824 transactions	Counts are based on the number of 2000: QTY01 Quantity segments.
Payer Initiated Eligibility/Benefit (PIE) Transaction (X279A1)	Counts are based on the number of members records in batch file

Financial Adjustment

a. EDI Transactions: The total amount payable each year shall remain fixed unless the EDI transactions volume falls outside the estimated high and low parameters for that year. Should the actual EDI

transaction volume, for a given year, fall outside the high and low estimated parameters, a year-end financial adjustment to the amount payable for operations for that year may be made using the following process:

b. The unit value will be set at 0.004 per transaction.

c. If the actual EDI transactions volume falls below the low estimate EDI transactions parameter, the Contractor shall reimburse the State a portion of the fixed price per the following calculation:

Low EDI Transactions Volume Estimate minus **Actual EDI Transactions Volume** x the unit value.

d. If the actual EDI transactions volume exceeds the high estimate EDI transactions parameter for the contract year, the State will make an additional payment to the Contractor per the following calculation:

Actual EDI Transactions minus **High EDI Transactions Volume Estimate** x unit value.

An adjustment in the fixed price payment to the Contractor for operations shall depend on verification and certification that actual EDI transaction counts are accurate and consistent with the definition of a claim as set forth this Section B.iii

iv. EVV Visit Transaction volume accounting and reconciliation of changes in Contractor Reimbursement.

The total amount payable each month shall remain fixed unless the EVV transactions volume exceeds the minimum estimated volume of 24,167 transactions. Any transaction over the minimum will be billed as utilized at the rate of $0.225 per transaction on a monthly basis.

The minimum monthly visit fee is calculated based on State provided data assuming 2,418 members, 20 visits per month:

- Total Monthly visits expected: 48,333 (580,000 annual)
- Expected Visits of 48,333 x 50% = 24,167 minimum visits
- 24,167 minimum visits x $0.225 per visit = $5,437

For all EVV transactions exceeding 24,167 per month, the Contractor will charge a per visit fee. A visit is defined as a single service delivery. Visits may be recorded using (a) telephony call into the Sandata system (b) the recording by the Sandata system of any of the following (i) the start of a visit, (ii) the end of a visit, (iii) the duration of a visit, (iv) a service performed during a visit, (v) corrections to any data in the Sandata EVV system or (vi) recording of a visit using the Sandata Mobile Connect Application.

v. EVV Aggregator PMPM transaction volume account and reconciliation of changes in Contractor Reimbursement

For all members whose data is received via third-party EVV systems interfacing with the Aggregator service, a per member per month (PMPM) fee of $1.375 will be assessed. The Contractor will provide a monthly count of all members who are associated with a third party EVV vendor from the Aggregator system to support the monthly fee.

9. MAPIR Collaborative Quarterly Payment

Table B.4 – MAPIR Payment Schedule

Time Period	Payment Date	Quarterly Price with 14 Members	Quarterly Price with 13 Members	Quarterly Price with 12 Members	Quarterly Price with 11 Members	Quarterly Price with 10 Members	Quarterly Price with 9 Members	Quarterly Price with 8 Members
Jan 2017 – Mar 2017	March 2017	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Apr 2017 – June 2017	June 2017	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Jul 2017 – Sep 2017	September 2017	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Oct 2017 – Dec 2017	December 2017	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Jan 2018 – Mar 2018	March 2018	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Apr 2018 -Jun 2018	June 2018	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Jul 2018 – Sep 2018	September 2018	$59,541.96	$64,122.12	$69,465.63	$75,780.68	$83,358.75	$92,620.83	$0
Oct 2018 – Dec 2018	December 2018	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Jan 2019 – Mar 2019	March 2019	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Apr 2019 – June 2019	June 2019	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Jul 2019 – Sep 2019	September 2019	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Oct 2019 – Dec 2019	December 2019	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Jan 2020 – Mar 2020	March 2020	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Apr 2020 – Jun 2020	June 2020	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Jul 2020 – Sep 2020	September 2020	$58,051.00	$62,517.00	$67,727.00	$73,884.00	$81,272.00	$90,302.00	$101,590.00
Oct 2020 – Dec 2020	December 2020	$58,051.00	$62,516.00	$67,726.00	$73,883.00	$81,271.00	$90,302.00	$101,589.00
Jan 2021 – Mar 2021	March 2021	$58,051.00	$62,516.00	$67,726.00	$73,883.00	$81,271.00	$90,302.00	$101,589.00
Apr 2021 – June 2021	June 2021	$29,026.00	$31,258.00	$33,863.00	$36,942.00	$40,636.00	$45,151.00	$50,795.00
Jul 2021 – Sep 2021	September 2021	$29,026.00	$31,258.00	$33,863.00	$36,942.00	$40,636.00	$45,151.00	$50,795.00
TOTAL FOR 57 MONTHS PER STATE		$1,055,355.72	$1,136,538.84	$1,231,253.41	$1,343,186.76	$1,477,501.25	$1,641,667.81	$1,117,488.00

10. Project Retainage

The Contractor agrees to a 10% retainage of each project invoice amount, for **One-time, Ongoing, and Future MMIS Modernization Projects** defined in Section III of Attachment A, and when the State has defined the initiative to be managed as a project. The State will only authorize the retainage payment for each individual project if all the following occur:

a. Contractor completes all deliverables associated with the project or specific payment in accordance with the acceptance criteria. The acceptance criteria shall be mutually agreed upon by the Parties.
b. State accepts all the milestones/deliverables for the project or specific payment based on the acceptance criteria.
c. Project enhancements are successfully operational for 30 calendar days to be qualified for reimbursement of the retained amount.

After all the above occur, the Contractor may submit a final invoice for payment of the total 10% retainage amount for that specific project. Hardware, software, and license payments are not subject to retainage. For projects that span beyond the State's fiscal year (ending June 30th), the Contractor shall submit an interim invoice and receive payment for the retainage for all deliverables completed and approved as described above by June 30th and December 31th of that year.

11. Customer Service Request Hours (CSRs)

The Contractor shall submit Specification Orders to the State for review and approval for the use of any CSR hours for making requested modifications to MMIS systems.

The Contractor agrees to provide 5,000 customer service hours per year in Years 1-3 to the State for making requested modifications to MMIS systems in each of the following years. This effort is included in the monthly fixed cost for Years 1-3 set forth in Section 5(A) of this Attachment B.

Unused hours for Years 1-3 shall expire each calendar year, except unused hours up to 1,000 hours may be used in the calendar years of 2018 and 2019. All unused hours from calendar year 2019 shall be carried forward into calendar year 2020 and shall be used first by the Contractor. Only after the 2019 carried forward hours are used the Contractor shall bill for State approved Specification Orders as utilized at the rates defined in Section 9 of this Attachment B.

12. Rate per Hour Billing

Effective January 1, 2021 the modification hourly rate will be increased annually from the base rate of $128.00 per hour at the Consumer Price Index (CPI) inflation rate. The Contractor shall bill the State for Task Order hours and Change Order hours utilizing this rate mechanism.

13. Task Order Hours

Task Orders shall be billed in accordance with this Attachment B, the Task Order specifications as agreed upon by both Parties, and this Attachment B. Task Order hours shall be billed at the CSR rate or for such fixed rate as the parties may agree, not to exceed $500,000 over the term of this Agreement.

14. Service Level Credits

The Contractor must adhere to the Technical and Functional Requirements and the Service Level Agreements set forth in Exhibit 1 and Exhibit 2 to Attachment A, and as subsequently amended, unless otherwise directed or authorized by the State in writing. This section describes the process by which the State may be entitled to an adjustment to the Service Credits for the Services.

Any remedy provided in this section for Contractor's failure to achieve a Service Level, including Service Level credits ("SLCs"), shall not limit or prevent the State from availing itself of concurrent or subsequent actions as stated within this Contract and permitted under State or federal laws. Based on this evaluation, the State may be entitled to adjustment to the Service Level Credits for the Services.

The following procedures shall govern this section:

a. Notification of Performance Failure: Written notification of each failure to meet a Service Level shall be given to the Contractor prior to assessing SLCs. The Contractor shall have five (5) business days from the date of receipt of written notification of a failure to perform to specifications to cure the failure. However, additional days can be approved by the State's Program Manager if deemed necessary. If the failure is not resolved within this 5-day warning/cure period, SLCs may be imposed from the date of the failure.

b. Determining Applicability of SLCs: After providing notice, and if the failure is not resolved within the warning/cure period, the State may (at its sole discretion) offset SLCs from the next subsequent monthly payment.

SERVICE LEVEL CREDITS (SLCs)

Triggering of SLCs

The Contractor shall apply a Service Level Credit:

A) In the amount provided within the SLA description upon failure to meet that one SLA.
B) Of $1,000 in any month in which the Contractor fails to meet four (4) or more SLAs whose descriptions call for a Cumulative Credit. *
C) Of $1,000 (per SLA) if the Contractor fails to meet any single SLA for three (3) or more months in a six (6) - month period. **

* If B is triggered for the Cumulative Credit, the total credit is $1,000 for the month. *This is not $1,000 per failed SLA.*
** If C is triggered for the repeated failure of a single SLA, the total credit is $1,000 per SLA that meets these criteria.

Invoice & Notice

The credit will be reported via a formal memo from the Contractor according to the notice terms provided in the Contract.

All credits shall be applied to the first invoice submitted by the Contractor following the triggering of the SLC.

The amount of total SLCs in a single calendar month shall not exceed the At-Risk Amount. If the State elects to seek other remedies and is awarded damages under this Contract, any Service Credits paid about or related to such failures or delays shall be deducted from any damages awarded or agreed upon.

If any of Contractor's reports or documentation to the State contain or state explicit information about failure to meet an SLC Condition per the above Table, then the State is automatically

entitled to the applicable SLC and does not need to follow the process in Section c below. The Contractor shall track and report any SLC failure to the State.

c. Reporting SLCs to Contractor: Within 30 calendar days following an SLC being triggered, the State shall inform the Contractor of the SLC by sending written notice to the Contractor and the notice shall contain the following information:
   1. The applicable performance failure and the applicable performance requirement.
   2. Any documentation evidencing Contractor's failure to adhere to performance requirements.
   3. Brief statement of the State's position and the appropriateness of the SLC.
   4. The SLC amount and the appropriateness of the amount of the SLC.

d. Contractor's Response / Dispute Resolution: Contractor's sole response to State's notice of SLC (if elected) shall be Dispute Resolution. The parties agree to be governed by the Dispute Resolution provision stated in Attachment D.

e. General Terms and Conditions of SLCs:
   1. All credits shall be applied to the first invoice submitted by the Contractor following the triggering of an SLC.
   2. If more than one event triggering a Service Level default has occurred within a single month, the sum of the corresponding SLCs (up to the At-Risk Amount) may be claimed by State. If a single event triggers multiple SLA's failure, the State, at its sole discretion, shall choose one SLC condition to apply.
   3. Regardless of the SLC's origin or basis, SLCs may be applied against any invoice from or payment to Contractor that is consistent with this section.
   4. The SLCs may not be applied to any payments or funds due to Contractor outside the scope of this Agreement.
   5. The Contractor shall report the Service Level Credit via a formal memo to the State according to the Notices to Parties term in this Contract. All credits shall be applied to the first invoice submitted by the Contractor following the triggering of an SLC.

f. Parties' Mutual Understanding of SLCs: SLCs credited hereunder shall not be deemed a penalty, but rather a cost adjustment attributable to the lower level of service delivery. Contractor acknowledges and agrees that Services delivered hereunder which meet the SLC Conditions set forth herein have inherently less value for the State and the SLCs represent a fair value for the services actually delivered; provided, however, the State shall retain all of its remedies in law or at equity in the event that the State is entitled to an SLC in any given month, subject to the Contractor's actual limitation on damages as set forth in Attachment D to this Contract.

g. At-Risk Amount: The At-Risk Amount is the maximum amount of SLCs under this Contract that the State may receive in the aggregate for Service Level defaults occurring during a single calendar month unless otherwise specified in this Section. The "At-Risk Amount" shall be 20% percent of any monthly invoice, as determined in accordance with Attachment B, Payment Provisions, that are payable by State to Contractor during a calendar month in accordance with the terms and conditions of Attachment B.

h. Excused Performance: Contractor(s) shall only be responsible to the extent a failure to meet the Service Levels was solely and directly caused by acts or omissions of Contractor(s) and/or Contractor's subcontractor. Contractor shall not be responsible to the extent caused by:
   1. any act(s) or omission(s) of third parties (excluding third parties provided by Contractor or other third parties engaged by Contractor in relation to these or any other services provided under an agreement with the State); or
   2. Force Majeure events (as defined in Attachment C, Section 26), except that a Force Majeure Event shall not excuse, delay or suspend Contractor's obligation to invoke and follow its Project Management Plan or any other business continuity or disaster recovery obligations set forth in this Contract in a timely fashion.

i. The Contractor shall:
   1. be liable for, and indemnify State from and against any negligent, unlawful or wrongful acts or omissions all acts or omissions of the Contractor (including their subcontractors, agents, and employees) which arise out of or directly relate to a loss or reduction of FFP (applicable to the services and deliverables under this agreement, and loss or reduction based on the maximum possible FFP eligible as if it were properly carried out), including their subcontractors, agents, and employees, except to the extent that such losses or reductions in FFP result from, in whole or in part, the negligence, unlawful or wrongful acts or omission of the State. This provision, and Contractor's responsibility thereunder, shall survive the term of this agreement to the extent allowed under state and federal law. The obligations in this Section will not exceed the limits on the Contractor's Liability as set forth in Section 8 of Attachment D.
   2. if there is reasonable certainty that FFP will be, or is, lost or reduced per subsection (a), the State may exercise any and all remedies available under this agreement, including but not limited to, the set off provision in Attachment C. Election of remedies under this agreement shall not foreclose, waive, or limit the State's ability to take further actions against Contractor (or its subcontractors, agents, and employees) to the extent allowed by law.

15. Total Budget

TABLE B.5 Total Operational and Project Costs

Total Budget 01/01/2017 – 12/31/2021	
MMIS Operations 5-year cost (includes bill as utilized operations)	$74,834,445.50
Incentive Payments ($160,000 max per year '17-19)	$480,000.00
MAPIR Core Development 1/1/17 thru 9/30/20	$890,362.04
MAPIR Core Development and Support 10/01/20 thru 9/30/21	$174,154.00
MAPIR Integration/Customization	$810,400.00
Payment and Delivery System (PADS) Reform	$1,178,180.00
Technology Updates – EDI	$443,750.00
Technology Updates – CM Platform	$125,000.00

TMSIS Enhancement	$2,068,107.00
Electronic Visit Verification Project (EVV) Implementation	$1,589,977.98
Provider Initiated Eligibility (PIE) Project	$62,500.00
Completed Projects	
Presumptive Eligibility: Completed	$32,082.00
Medicare Grant Project: Completed – fixed price	$13,200.00
Provider 6028 Project: Completed	$2,795.14
Medicare Card Project: Completed	$33,555.26
All Payer Model: Completed	$117,142.46
Provider Services Enhancement Project: Completed	$3,022,826.00
Total 'Not to Exceed' Contract Budget	**$85,878,477.38**

15.1 December 21, 2017, project hours were based on an estimated average of $120.61 per hour, to vary depending on the CPI rate as described in Section 9 of this Attachment B.
15.2 2019 New Project hours were based on an estimated average of $125.00 per hour, to vary depending on the CPI rate as described in Section 9 of this Attachment B. (Actual 2019 hourly bill rate was $125.48.)
15.3 Monthly costs for additional Contractor space, EVV PMPM charges, CSR hours, and postage charges shall be billed as utilized.
15.4 Amendment 4 new project costs were based on an estimated average of $128.00 per hour, to vary depending on the CPI rate as described in Section 9 of this Attachment B.
15.5 Amendment 5 project cost updates were based on an estimated average of $130.00 per hour, to vary depending on the CPI rate as described in Section 9 of this Attachment B.

16. **Payments Upon Termination.** At the time of termination, whether partial or full, the Contractor shall invoice and State shall issue payment for partially completed services or deliverables satisfactorily delivered to and not yet approved by the State and reasonable shut down expenses for which Contractor can provide sufficient evidence and shall be at a price mutually agreed upon by the Contractor and the State.

Appendix III

Attachment E beginning on page 94 of 106 of the base agreement, and as previously amended, is hereby deleted, and replaced with the Attachment E dated May 22, 2020.

ATTACHMENT E
BUSINESS ASSOCIATE AGREEMENT

SOV CONTRACTOR: DXC MS LLC

SOV CONTRACT No. 35485A **CONTRACT Effective Date:** January 1, 2015

THIS BUSINESS ASSOCIATE AGREEMENT ("AGREEMENT") IS ENTERED INTO BY AND BETWEEN THE STATE OF VERMONT AGENCY OF HUMAN SERVICES, OPERATING BY AND THROUGH ITS DEPARTMENT OF VERMONT HEALTH ACCESS ("COVERED ENTITY") AND PARTY IDENTIFIED IN THIS AGREEMENT AS CONTRACTOR OR GRANTEE ABOVE ("BUSINESS ASSOCIATE"). THIS AGREEMENT SUPPLEMENTS AND IS MADE A PART OF THE CONTRACT OR GRANT ("CONTRACT OR GRANT") TO WHICH IT IS ATTACHED.
Covered Entity and Business Associate enter into this Agreement to comply with the standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the Standards for the Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164 ("Privacy Rule"), and the Security Standards, at 45 CFR Parts 160 and 164 ("Security Rule"), as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH), and any associated federal rules and regulations.

The parties agree as follows:

1. **Definitions**. All capitalized terms used but not otherwise defined in this Agreement have the meanings set forth in 45 CFR Parts 160 and 164 as amended by HITECH and associated federal rules and regulations. Terms defined in this Agreement are italicized. Unless otherwise specified, when used in this Agreement, defined terms used in the singular shall be understood if appropriate in their context to include the plural when applicable.

"*Agent*" means an *Individual* acting within the scope of the agency of the *Business Associate*, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c) and includes Workforce members and *Subcontractors*.

"*Breach*" means the acquisition, Access, Use or Disclosure of *Protected Health Information* (*PHI*) which compromises the Security or privacy of the *PHI*, except as excluded in the definition of *Breach* in 45 CFR § 164.402.

"*Business Associate*" shall have the meaning given for "Business Associate" in 45 CFR § 160.103 and means Contractor or Grantee and includes its Workforce, *Agents* and *Subcontractors*.

"*Electronic PHI*" shall mean *PHI* created, received, maintained or transmitted electronically in accordance with 45 CFR § 160.103.

"*Individual*" includes a Person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

"*Protected Health Information*" ("*PHI*") shall have the meaning given in 45 CFR § 160.103, limited to the *PHI* created or received by *Business Associate* from or on behalf of Covered Entity.

"*Required by Law*" means a mandate contained in law that compels an entity to make a use or disclosure of *PHI* and that is enforceable in a court of law and shall have the meaning given in 45 CFR § 164.103.

"*Report*" means submissions required by this Agreement as provided in section 2.3.

"*Security Incident*" means the attempted or successful unauthorized Access, Use, Disclosure, modification, or destruction of Information or interference with system operations in an Information System relating to *PHI* in accordance with 45 CFR § 164.304.

"*Services*" includes all work performed by the *Business Associate* for or on behalf of Covered Entity that requires the Use and/or Disclosure of *PHI* to perform a *Business Associate* function described in 45 CFR § 160.103.

"*Subcontractor*" means a Person to whom *Business Associate* delegates a function, activity, or service, other than in the capacity of a member of the workforce of such *Business Associate*.

"*Successful Security Incident*" shall mean a *Security Incident* that results in the unauthorized Access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System.

"*Unsuccessful Security Incident*" shall mean a *Security Incident* such as routine occurrences that do not result in unauthorized Access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System, such as: (i) unsuccessful attempts to penetrate computer networks or services maintained by *Business Associate*; and (ii) immaterial incidents such as pings and other broadcast attacks on *Business Associate's* firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above with respect to *Business Associate's* Information System.

"*Targeted Unsuccessful Security Incident*" means an *Unsuccessful Security Incident* that appears to be an attempt to obtain unauthorized Access, Use, Disclosure, modification or destruction of the Covered Entity's *Electronic PHI*.

2. <u>Contact Information for Privacy and Security Officers and Reports.</u>

2.1 *Business Associate* shall provide, within ten (10) days of the execution of this Agreement, written notice to the Contract or Grant manager the names and contact information of both the HIPAA Privacy Officer and HIPAA Security Officer of the *Business Associate.* This information must be updated by *Business Associate* any time these contacts change.

2.2 Covered Entity's HIPAA Privacy Officer and HIPAA Security Officer contact information is posted at: https://humanservices.vermont.gov/rules-policies/health-insurance-portability-and-accountability-act-hipaa

2.3 *Business Associate* shall submit all *Reports* required by this Agreement to the following email address: AHS.PrivacyAndSecurity@vermont.gov

3. Permitted and Required Uses/Disclosures of PHI.

3.1 Subject to the terms in this Agreement, *Business Associate* may Use or Disclose *PHI* to perform *Services*, as specified in the Contract or Grant. Such Uses and Disclosures are limited to the minimum necessary to provide the *Services*. *Business Associate* shall not Use or Disclose *PHI* in any manner that would constitute a violation of the Privacy Rule if Used or Disclosed by Covered Entity in that manner. *Business Associate* may not Use or Disclose *PHI* other than as permitted or required by this Agreement or as *Required by Law* and only in compliance with applicable laws and regulations.

3.2 *Business Associate* may make *PHI* available to its Workforce, *Agent* and *Subcontractor* who need Access to perform *Services* as permitted by this Agreement, provided that *Business Associate* makes them aware of the Use and Disclosure restrictions in this Agreement and binds them to comply with such restrictions.

3.3 *Business Associate* shall be directly liable under HIPAA for impermissible Uses and Disclosures of *PHI*.

4. Business Activities. *Business Associate* may Use *PHI* if necessary for *Business Associate's* proper management and administration or to carry out its legal responsibilities. *Business Associate* may Disclose *PHI* for *Business Associate's* proper management and administration or to carry out its legal responsibilities if a Disclosure is *Required by Law* or if *Business Associate* obtains reasonable written assurances via a written agreement from the Person to whom the information is to be Disclosed that such *PHI* shall remain confidential and be Used or further Disclosed only as *Required by Law* or for the purpose for which it was Disclosed to the Person, and the Agreement requires the Person to notify *Business Associate*, within five (5) business days, in writing of any *Breach* of Unsecured *PHI* of which it is aware. Such Uses and Disclosures of *PHI* must be of the minimum amount necessary to accomplish such purposes.

5. Electronic PHI Security Rule Obligations.

5.1 With respect to *Electronic PHI*, *Business Associate* shall:

a) Implement and use Administrative, Physical, and Technical Safeguards in compliance with 45 CFR sections 164.308, 164.310, and 164.312;

b) Identify in writing upon request from Covered Entity all the safeguards that it uses to protect such *Electronic PHI*;

c) Prior to any Use or Disclosure of *Electronic PHI* by an *Agent* or *Subcontractor*, ensure that any *Agent* or *Subcontractor* to whom it provides *Electronic PHI* agrees in writing to implement and use Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of *Electronic PHI*. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce

any breach of the agreement concerning the Use or Disclosure of *Electronic PHI*, and be provided to Covered Entity upon request;

d) Report in writing to Covered Entity any *Successful Security Incident* or *Targeted Unsuccessful Security Incident* as soon as it becomes aware of such incident and in no event later than five (5) business days after such awareness. Such *Report* shall be timely made notwithstanding the fact that little information may be known at the time of the *Report* and need only include such information then available;

e) Following such *Report*, provide Covered Entity with the information necessary for Covered Entity to investigate any such incident; and

f) Continue to provide to Covered Entity information concerning the incident as it becomes available to it.

5.2 Reporting *Unsuccessful Security Incidents. Business Associate* shall provide Covered Entity upon written request a *Report* that: (a) identifies the categories of Unsuccessful Security Incidents; (b) indicates whether *Business Associate* believes its current defensive security measures are adequate to address all *Unsuccessful Security Incidents*, given the scope and nature of such attempts; and (c) if the security measures are not adequate, the measures *Business Associate* will implement to address the security inadequacies.

5.3 *Business Associate* shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

6. <u>Reporting and Documenting Breaches</u>.

6.1 *Business Associate* shall *Report* to Covered Entity any *Breach* of Unsecured *PHI* as soon as it, or any Person to whom *PHI* is disclosed under this Agreement, becomes aware of any such *Breach*, and in no event later than five (5) business days after such awareness, except when a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. Such *Report* shall be timely made notwithstanding the fact that little information may be known at the time of the *Report* and need only include such information then available.

6.2 Following the *Report* described in 6.1, *Business Associate* shall conduct a risk assessment and provide it to Covered Entity with a summary of the event. *Business Associate* shall provide Covered Entity with the names of any *Individual* whose Unsecured *PHI* has been, or is reasonably believed to have been, the subject of the *Breach* and any other available information that is required to be given to the affected *Individual*, as set forth in 45 CFR § 164.404(c). Upon request by Covered Entity, *Business Associate* shall provide information necessary for Covered Entity to investigate the impermissible Use or Disclosure. *Business Associate* shall continue to provide to Covered Entity information concerning the *Breach* as it becomes available.

6.3 When *Business Associate* determines that an impermissible acquisition, Access, Use or Disclosure of *PHI* for which it is responsible is not a *Breach*, and therefore does not necessitate notice to the impacted *Individual*, it shall document its assessment of risk, conducted as set forth

in 45 CFR § 402(2). *Business Associate* shall make its risk assessment available to Covered Entity upon request. It shall include 1) the name of the person making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons supporting the determination of low probability that the *PHI* had been compromised.

7. Mitigation and Corrective Action. *Business Associate* shall mitigate, to the extent practicable, any harmful effect that is known to it of an impermissible Use or Disclosure of *PHI*, even if the impermissible Use or Disclosure does not constitute a *Breach*. *Business Associate* shall draft and carry out a plan of corrective action to address any incident of impermissible Use or Disclosure of *PHI*. *Business Associate* shall make its mitigation and corrective action plans available to Covered Entity upon request.

8. Providing Notice of Breaches.

8.1 If Covered Entity determines that a *Breach* of *PHI* for which *Business Associate* was responsible, and if requested by Covered Entity, *Business Associate* shall provide notice to the *Individual* whose *PHI* has been the subject of the *Breach*. When so requested, *Business Associate* shall consult with Covered Entity about the timeliness, content and method of notice, and shall receive Covered Entity's approval concerning these elements. *Business Associate* shall be responsible for the cost of notice and related remedies.

8.2 The notice to affected *Individuals* shall be provided as soon as reasonably possible and in no case later than sixty (60) calendar days after *Business Associate* reported the *Breach* to Covered Entity.

8.3 The notice to affected *Individuals* shall be written in plain language and shall include, to the extent possible: 1) a brief description of what happened; 2) a description of the types of Unsecured *PHI* that were involved in the *Breach*; 3) any steps *Individuals* can take to protect themselves from potential harm resulting from the *Breach*; 4) a brief description of what the *Business Associate* is doing to investigate the *Breach* to mitigate harm to *Individuals* and to protect against further *Breaches*; and 5) contact procedures for *Individuals* to ask questions or obtain additional information, as set forth in 45 CFR § 164.404(c).

8.4 *Business Associate* shall notify *Individuals* of *Breaches* as specified in 45 CFR § 164.404(d) (methods of *Individual* notice). In addition, when a *Breach* involves more than 500 residents of Vermont, *Business Associate* shall, if requested by Covered Entity, notify prominent media outlets serving Vermont, following the requirements set forth in 45 CFR § 164.406.

9. Agreements with Subcontractors. *Business Associate* shall enter into a Business Associate Agreement with any *Subcontractor* to whom it provides *PHI* to require compliance with HIPAA and to ensure *Business Associate* and *Subcontractor* comply with the terms and conditions of this Agreement. *Business Associate* must enter into such written agreement before any Use by or Disclosure of *PHI* to such *Subcontractor*. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the Use or Disclosure of *PHI*. *Business Associate* shall provide a copy of the written agreement it enters into with a *Subcontractor* to Covered Entity upon request. *Business Associate* may not make any Disclosure of *PHI* to any *Subcontractor* without prior written consent of Covered Entity.

10. **Access to PHI**. *Business Associate* shall provide access to *PHI* in a Designated Record Set to Covered Entity or as directed by Covered Entity to an *Individual* to meet the requirements under 45 CFR § 164.524. *Business Associate* shall provide such access in the time and manner reasonably designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any request for Access to *PHI* that *Business Associate* directly receives from an *Individual*.

11. **Amendment of PHI**. *Business Associate* shall make any amendments to *PHI* in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, whether at the request of Covered Entity or an *Individual*. *Business Associate* shall make such amendments in the time and manner reasonably designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any request for amendment to *PHI* that *Business Associate* directly receives from an *Individual*.

12. **Accounting of Disclosures**. *Business Associate* shall document Disclosures of *PHI* and all information related to such Disclosures as would be required for Covered Entity to respond to a request by an *Individual* for an accounting of disclosures of *PHI* in accordance with 45 CFR § 164.528. *Business Associate* shall provide such information to Covered Entity or as directed by Covered Entity to an *Individual*, to permit Covered Entity to respond to an accounting request. *Business Associate* shall provide such information in the time and manner reasonably designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any accounting request that *Business Associate* directly receives from an *Individual*.

13. **Books and Records**. Subject to the attorney-client and other applicable legal privileges, *Business Associate* shall make its internal practices, books, and records (including policies and procedures and *PHI*) relating to the Use and Disclosure of *PHI* available to the Secretary of Health and Human Services (HHS) in the time and manner designated by the Secretary. *Business Associate* shall make the same information available to Covered Entity, upon Covered Entity's request, in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether *Business Associate* is in compliance with this Agreement.

14. **Termination.**

14.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all the *PHI* is destroyed or returned to Covered Entity subject to Section 18.8.

14.2 If *Business Associate* fails to comply with any material term of this Agreement, Covered Entity may provide an opportunity for *Business Associate* to cure. If *Business Associate* does not cure within the time specified by Covered Entity or if Covered Entity believes that cure is not reasonably possible, Covered Entity may immediately terminate the Contract or Grant without incurring liability or penalty for such termination. If neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary of HHS. Covered Entity has the right to seek to cure such failure by *Business Associate*. Regardless of whether Covered Entity cures, it retains any right or remedy available at law, in equity, or under the Contract or Grant and *Business Associate* retains its responsibility for such failure.

15. Return/Destruction of PHI.

15.1 *Business Associate* in connection with the expiration or termination of the Contract or Grant shall return or destroy, at the discretion of the Covered Entity, *PHI* that *Business Associate* still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. *Business Associate* shall not retain any copies of *PHI*. *Business Associate* shall certify in writing and report to Covered Entity (1) when all *PHI* has been returned or destroyed and (2) that *Business Associate* does not continue to maintain any *PHI*. *Business Associate* is to provide this certification during this thirty (30) day period.

15.2 *Business Associate* shall report to Covered Entity any conditions that *Business Associate* believes make the return or destruction of *PHI* infeasible. *Business Associate* shall extend the protections of this Agreement to such *PHI* and limit further Uses and Disclosures to those purposes that make the return or destruction infeasible for so long as *Business Associate* maintains such *PHI*.

16. Penalties. *Business Associate* understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of *PHI* and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations.

17. Training. *Business Associate* understands its obligation to comply with the law and shall provide appropriate training and education to ensure compliance with this Agreement. If requested by Covered Entity, *Business Associate* shall participate in Covered Entity's training regarding the Use, Confidentiality, and Security of *PHI*; however, participation in such training shall not supplant nor relieve *Business Associate* of its obligations under this Agreement to independently assure compliance with the law and this Agreement.

18. Miscellaneous.

18.1 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of the Contract or Grant, the terms of this Agreement shall govern with respect to its subject matter. Otherwise, the terms of the Contract or Grant continue in effect.

18.2 Each party shall cooperate with the other party to amend this Agreement from time to time as is necessary for such party to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA. This Agreement may not be amended, except by a writing signed by all parties hereto.

18.3 Any ambiguity in this Agreement shall be resolved to permit the parties to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.

18.4 In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule, Security Rule, and HITECH) in construing the meaning and effect of this Agreement.

18.5 *Business Associate* shall not have or claim any ownership of *PHI*.

18.6 *Business Associate* shall abide by the terms and conditions of this Agreement with respect to all *PHI* even if some of that information relates to specific services for which *Business Associate* may not be a "*Business Associate*" of Covered Entity under the Privacy Rule.

18.7 *Business Associate* is prohibited from directly or indirectly receiving any remuneration in exchange for an *Individual's PHI*. *Business Associate* will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. *Reports* or data containing *PHI* may not be sold without Covered Entity's or the affected Individual's written consent.

18.8 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for *Business Associate* to return or destroy *PHI* as provided in Section 14.2 and (b) the obligation of *Business Associate* to provide an accounting of disclosures as set forth in Section 12 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.